ASSESSING AND MANAGING THE PATIENT'S NEEDS IN THE PALLIATIVE CARE SETTING

OBJECTIVES

Outstanding symptom management is a core objective of patient-centered palliative care. In this section, you will review different ways to assess and manage pain and a number of other symptoms commonly experienced by patients at the end of life, including nausea, constipation, dyspnea, and delirium. The patient's cultural framework and spiritual beliefs are also an important part of the palliative care assessment, as these contribute to the patient's interpretation and experience of his/her illness. It is therefore important for the clinician to develop ways of understanding the whole patient so that truly patient-centered—rather than merely symptom-centered—care can be achieved.

TOPICS

- Types of pain
- Opioid dose conversions
- Opioid dose escalation
- Opioid titration in the imminently dying patient
- Myth of morphine and hastened death
- Non-pain symptom management
- Syndrome of Imminent Death
- FICA: Assessing spiritual beliefs and needs in the palliative patient

Pain Assessment and Management in Palliative Care

Pain is an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage. The mnemonic **PAIN** can be used to consider the various factors (physical/functional, emotional/psychological, social, and spiritual) that affect a patient's perception and tolerance of pain:

Physical component (both etiology and effects on physical functioning)
Anxiety and depression
Interpersonal factors (guilt, loss of trust, psychosocial and financial stressors)
Not accepting (hope, meaning, faith, existential distress)

CHARACTERIZE PAIN

1. Nociceptive pain (generated by a noxious stimulus and sensed by a pain fiber)

Somatic
Localized pain due to soft tissue damage
Descriptors: Sharp, prick-like, stabbing, throbbing, aching

Visceral
Poorly localized pain caused by stretch, ischemia, or inflammation of internal organs
Descriptors: Dull, deep, gnawing, cramping, squeezing

Drugs: Opioids, Tylenol, NSAIDs

2. Neuropathic pain

May result from direct nerve injury (diabetic neuropathy, post-herpetic neuralgia), or have CNS etiology
Descriptors: Burning, shooting, electric shocks
Drugs: Antidepressants (TCAs, effexor, cymbalta) and Antiepileptics (Gabapentin, lyrica, etc)

DOCUMENT PAIN

- Verbal adolescents and adults: 0-10 visual analog pain scale
- Infants, nonverbal children, nonverbal adults: Use nonverbal pain scale that evaluates breathing patterns, facial expression, vocalizations, body language, and consolability to assess severity
- Verbal children: Facial image-based scale

PAIN TREATMENT

Depending on etiology and severity, you will generally start with the WHO pain ladder. Consider whether adjuvants (e.g. TCAs, anticonvulsants, muscle relaxants, corticosteroids, bisphosphanates, lidocaine and other topical agents) are indicated. See the following pages for further information. Do not forget that:

- **Clinical assessment should be ongoing.** Patients' needs will change over time.
- **Compassionate care requires that you listen and be present.** Patients and their families need to feel they will not be abandoned. Continue to discuss goals of care and address the patient's hopes and fears. Pay attention to subtle cues that will give you insight into how each patient and family wants to receive information. Be mindful of cultural/spiritual traditions that may become more important in the dying patient.

The Basics in Opioid prescribing and Dose Conversions

1) Commonly Used Opioid Preparations

Mild Pain	*Moderate or Severe Pain*			
Oral	*Oral*		*Parenteral (IV)*	
Short acting	*Short Acting*	*Long Acting*	*Short Acting*	*Long Acting*
Vicodin (hydrocodone/tylenol) Norco (hydrocodone/tylenol) Percocet (oxycodone/tylenol) Tylenol #3	Morphine* Oxycodone Hydromorphone (dilaudid)	MS Contin* Oxycontin	Morphine* Hydromorphone Fentanyl	Morphine infusion* Hydromorphone infusion Fentanyl infusion Fentanyl transdermal

* Avoid in patients with renal failure

2) **Choosing an initial Opioid regimen:** For initial dosing, start only with short acting medication used prn. Consider lower starting doses for elderly/frail patients or those with liver and/or renal failure

	Initial Doses	**Frequency**
Oral	Morphine* 7.5 (half of 15mg tablet) Oxycodone 5mg Norco (Hydrocodone/Tylenol) 5mg Dilaudid 1mg	Q2-4 hrs
Parenteral	Morphine* 2-5mg Hydromorphone 0.5-2mg Fentanyl 25-50mcg	Q1-4 hours
Bowel regimen	Senna 2 tabs	QHS

* Avoid in patients with renal failure

3) **Titrating opioids:** As opioid requirements increase, use a long acting medication dosed regularly, and continue short acting medication prn (for breakthrough pain)
   a. Long acting: total daily dose = 50-100% of total breakthrough used in 24 hours (in addition to long-acting patient is already taking)
   b. Breakthrough: each dose = 10-20% of total daily long-acting dose (as short acting preparation)

4) Converting Between Opioid Routes and Drugs
   a. Step 1: Calculate 24 hour dose of current drug
   b. Step 2: Reduce dose for incomplete cross tolerance: 25-50%
   c. Step 3: Using conversion chart (below), calculate 24 hour dose of new drug
   d. Step 4: Calculate long acting dose if using (50-100% of calculated daily usage of new drug, adjusted for cross tolerance), and breakthrough dose (each dose = 10-20% of 24 hr calculated long acting dose)

	Equianalgesic Equivalence (mg)	
OPIOID	PARENTERAL	ORAL
Morphine	10	25
Fentanyl	0.15	NA
Hydrocodone	NA	25
Hydromorphone	2	5
Oxycodone	10 *(not in US)*	20
Oxymorphone	1	10

*Example using conversion table: A patient is taking oxycodone 10mg PO every 6 hours with well controlled pain, and you would like to change this to oral hydromorphone (dilaudid)
1) 10mg oxycodone every 6 hours = 40mg oxycodone 24 hours
2) Reduction for incomplete cross tolerance by 50% = 20mg oxycodone 24 hours
3) 20 mg oxycodone x (5/20) = 5mg hydromorphone/24 hours
4) 5mg divided into q 6 hour dosing = roughly 1mg oral dilaudid every 6 hours

Opioid Dose Escalation

David E Weissman MD

Fast Fact #20: https://www.capc.org/fast-facts/20-opioid-dose-escalation/

Background: A common question from trainees is how fast, and by how much, can opioids be safely dose escalated? I like to use the analogy of furosemide (Lasix) when discussing this topic. I have never seen a resident order an increase in Lasix from 10 mg to 11 mg, yet that is precisely what often happens with opioids, especially parenteral infusions. Like furosemide, dose escalation of opioids should be done on the basis of a percentage increase. In fact, this is reflexively done when opioid-non-opioid fixed combination products are prescribed; going from one to two tablets of codeine/acetaminophen represents a 100% dose increase. The problem arises when oral single agents (e.g. oral morphine) or parenteral infusions are prescribed. Increasing a morphine infusion from 1 to 2 mg/hr is a 100% does increase; while going from 5 to 6 mg/hr is only a 20% increase, and yet many orders are written, "increase drip by 1 mg/hr, titrate to comfort." Some hospitals and nursing units even have this as a standing pre-printed order or nursing policy.

Key Point: **In general, patients do not notice a change in analgesia when dose increases are less than 25% above baseline.** There is a paucity of clinical trial data on this subject. A common formula used by many practitioners is:

- For ongoing moderate to severe pain increase opioids doses by 50-100%, irrespective of starting dose.
- For ongoing mild to moderate pain increase by 25-50%, irrespective of starting dose.
- When dose escalating long-acting opioids or opioid infusions, do not increase the long-acting drug or infusion basal rate more than 100% at any one time, irrespective of how many bolus/breakthrough doses have been used. These guidelines apply to patients with normal renal and hepatic function. For elderly patients, or those with renal/liver disease, dose escalation percentages should be reduced.

When dose escalating long-acting opioids or opioid infusions, do not increase the long-acting drug or infusion basal rate more than 100% at any one time, irrespective of how many bolus/breakthrough doses have been used. These guidelines apply to patients with normal renal and hepatic function. For elderly patients, or those with renal/liver disease, dose escalation percentages should be reduced.

The recommended frequency of dose escalation depends on the half-life of the drug.

- Short-acting oral single-agent opioids (e.g. morphine, oxycodone, hydromorphone), can be safely dose escalated every 2 hours.
- Sustained release oral opioids can be escalated every 24 hours.
- For methadone, levorphanol, or transdermal fentanyl no more frequently than every 72 hours is recommended.

See related analgesic Fast Facts:
Fast Fact #18 Oral opioid dosing intervals
Fast Fact #51 Opioid combination products
Fast Fact #70 PRN range orders
Fast Fact #74 Good and Bad analgesic orders

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Opioid Infusions In The Imminently Dying Patient

David E Weissman MD, Elizabeth Weinstein, Robert M Arnold MD

Fast Fact #54: https://www.capc.org/fast-facts/54-opioid-infusions-imminently-dying-patient/

Introduction: Opioid infusions, either intravenous (IV) or subcutaneous (SQ – see Fast Fact #28), can provide smooth and efficient control of distressing pain or dyspnea in the imminently dying patient. Opioids correctly titrated to provide symptom relief will not cause respiratory depression (see Fast Fact #8). It is common for physicians to order an opioid infusion in the dying patient as follows: Start morphine infusion at 1 mg/hr, titrate to effect. This type of order is pharmacologically unsound and unsafe; hospitals should adopt clinical practice guidelines that meet current national standards. The following is a step by step approach to rational opioid infusion prescribing in the dying patient, and is most appropriate for morphine or hydromorphone infusions; a future Fast Fact will discuss the use of methadone.

1. Before starting an opioid infusion, calculate an equianalgesic dose of currently used opioids; then convert this to an equianalgesic basal rate.

> Example: a patient on oral extended release morphine 60 mg q12, now unable to swallow. 60 mg q 12 = 120 mg/24 hours PO morphine = 40 mg IV morphine/24 hours = approximately 2 mg/hr IV infusion basal rate).

2. If the current opioid dose is not effective, dose escalate the basal dose by 25-100% (see Fast Fact #20).

3. If the patient is opioid naïve or when increasing the basal rate above the current equianalgesic rate, give a loading dose when starting the infusion.

> Example: for a 1 mg/hr basal rate, give 2-5 mg loading dose (see reference 4 for additional dosing guidelines).

4. Choose a bolus dose (i.e. 'rescue' or 'PCA' dose if a patient controlled analgesia system is being used).

This can be a nurse initiated bolus dose when using a standard IV infuser, or a patient, nurse or family initiative bolus using a PCA device. Even though the dying patient may be unable to press the button, the nurse or family members can use the PCA device, depending on local hospital policy. Based on patterns of breakthrough pain, a bolus dose of 50% - 150% of the hourly rate is a place to start. For example, for a morphine infusion of 2 mg/hr, choose a starting bolus dose of 1-3 mg.

5. Choose a dosing interval.

The peak analgesic effect from an IV bolus dose is 5-10 minutes. Thus, the dosing interval (i.e. 'lockout interval' for a PCA device) should be in the range of 10-20 minutes.

6. Reassess for desired effect vs. side effects every 10-15 minutes until stable.

Adjust bolus dose size every 30-60 minutes until desired effect is achieved. The 'right' bolus dose is one which controls undesirable symptoms with acceptable toxicities.

7. Reassess the need for a change in the basal rate no more frequently than every 6-8 hours.

Use the number of administered bolus doses as a rough guide when calculating a new basal rate; never, however, increase the basal rate by more than 100% at any one time. When increasing the basal rate, always administer a loading dose so as to more rapidly achieve steady-state blood levels.

Common sense caution

The above guidelines should be thought of as a rough guide; differences in age, renal and pulmonary function and past responses to opioids must be considered when developing an appropriate analgesic treatment plan. When patients become anuric close to death, continuous dosing may be discontinued in favor of bolus dosing to prevent metabolite accumulation and agitated delirium.

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Morphine And Hastened Death

Charles F von Gunten MD

Fast Fact #8, 2009: https://www.capc.org/fast-facts/8-morphine-and-hastened-death/

Question: What is the distinction between the use of morphine at the end of life to control symptoms and euthanasia/assisted suicide?

Case Scenario: An 83 year old former industrial worker has been hospitalized because of severe pain. He has pancreatic cancer with metastases to liver and lung. He has severe abdominal pain, and opioid therapy with morphine is recommended for pain relief.

1. Many physicians inaccurately believe that morphine has an unusually or unacceptably high risk of an adverse event that may cause death, particularly when the patient is frail or close to the end of his or her life. In fact, morphine-related toxicity will be evident in sequential development of drowsiness, confusion, then loss of consciousness before respiratory drive is significantly compromised.

2. Many physicians inappropriately call this risk of a potentially adverse event, a double effect, when it is in fact a secondary, unintended consequence. The principle of double effect refers to the ethical construct where a physician uses a treatment, or gives medication, for an ethical intended effect where the potential outcome is good (eg, relief of a symptom), knowing that there will certainly be an undesired secondary effect (such as death). An example might be the separation of conjoined twins knowing that one twin will die so that the other will live. Although this principle of "double effect" is commonly cited with morphine, in fact, it does not apply, as the secondary adverse consequences are unlikely.

3. When offering a therapy, it is the intent in offering a treatment that dictates whether it is ethical medical practice:

A. If the *intent* in offering a treatment is *desirable* or *helpful* to the patient and the *potential outcome good* (such as relief of pain), but a potentially adverse secondary effect is undesired and the *potential outcome bad* (such as death), then *the treatment is considered ethical.*

B. If the *intent* is *not desirable* or *will harm* the patient and *the potential outcome bad*, the *treatment is considered unethical.*

4. All medical treatments have both intended effects and the risk of unintended, potentially adverse, secondary consequences, including death. Some examples are total parenteral nutrition, chemotherapy, surgery, amiodarone, etc.

5. Assisted suicide and euthanasia are not examples of "double effect." The intention in offering the treatment in assisted suicide and euthanasia is to end the patient's life.

6. If the intent for using morphine in the scenario is to relieve pain and not to cause death, and accepted dosing guidelines are followed:

A. the treatment is considered ethical,

B. the risk of a potentially dangerous adverse secondary effects particularly hastening death is minimal, and

C. the risk of respiratory depression is vastly over-estimated.

References

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Common Non-Pain Symptoms in the Palliative Patient

CONSTIPATION

Constipation is defined relative to a patient's baseline stool patterns. It may present with abdominal pain, nausea, vomiting, diarrhea, flatulence, urinary retention, anorexia, abdominal distension, and/or straining with defecation. Many medications can cause or exacerbate constipation, including:

- Opioids
- Anti-cholinergics (anti-spasmotics, antidepressants)
- Antipsychotics
- Iron
- Verapamil
- 5HT3 antagonists (ondansetron)
- Diuretics
- Chemotherapy

Other causes include hypercalcemia, hypothyroidism, and hypokalemia, an neural causes (e.g, epidural spinal cord compression). Bowel obstruction and ileus can cause similar changes in stool patterns. A KUB can differentiate between the three.

Pharmacologic management of constipation

- Stimulants (bisacodyl, senna)
  NOTE THAT ALL PATIENTS ON OPIOIDS SHOULD BE ON A BOWEL STIMULANT
- Osmotic laxatives (sorbitol, lactulose, polyethylene glycol, magnesium citrate)
- Rectal based laxatives:
  - Suppositories: bisacodyl (stimulant), lubricants (glycerin)
  - Enemas (mineral oil, sodium phosphate, tap water)
- Opioid antagonists (naloxone, methylnaltrexone)
- Bulk-forming agents (e.g psyllium, methylcellulose)

In most palliative care patients, bulk-forming agents should be avoided, as these patients tend to have reduced fluid intake and decreased mobility, and are likely on opioids. In general, the treatment of constipation should follow a stepwise approach:

- **Step 1**: STIMULANT +/- osmotic agent
- **Step 2**: Add osmotic agents
- **Step 3**: Consider rectal based laxatives
- **Step 4**: Consider opioid antagonists

DELIRIUM

Reduced cognitive function or otherwise altered mental status is common in the weeks prior to death, and should prompt a focused assessment. Delirium can be either hyperactive (agitated) or hypoactive, and can be reversible or irreversible (terminal delirium). It can be manifested as an altered sleep/wake cycle, mumbling speech, and cognitive and/or perceptual disturbances (impaired memory/attention, delusions, hallucinations).

Delirium — Mnemonic **FACT**:

- **F**luctuating cognitive deficit(s) with acute onset
- **A**ttention deficits, and either
- **C**onsciousness level disturbance, or
- **T**hought disorganization

The degree of work-up for underlying causes should be dictated by the overall prognosis and goals of care. The most common identifiable cause of delirium in the hospital setting is drugs: anti-cholinergics (e.g. anti-emetics, anti-histamines, anti-secretion drugs, TCAs, etc.), sedative-hypnotics (e.g. benzodiazepines), and opioids. Other common causes include drug/alcohol withdrawal, infections, CNS pathology, or metabolic derangements (elevated sodium or calcium, low glucose or oxygen).

Non-pharmacological management of delirium

- Reduce or increase the sensory stimulation in the environment as needed (hearing aids, glasses, etc)
- Ask relatives/friends to stay by the patient
- Frequent reminders of time/place

Pharmacologic management of delirium

- Drug of choice for most patients is a neuroleptic, usually haloperidol 0.5-2 mg PO or IV q1-4hours PRN
- If anxiety is a prominent part of a patient's delirium, a benzodiazepine may help. Generally, however, benzodiazepines should be avoided as they can cause paradoxical worsening of the delirium and agitation.

DYSPNEA

Dyspnea, the patient's subjective feeling of shortness of breath (or breathlessness, or difficulty breathing), is a common symptom at the end of life. It may or may not be associated with tachypnea, hyperventilation, and/or hypoxemia. If consistent with the patient's goals of care, a work-up (e.g CXR, hematocrit) for potentially reversible causes of dyspnea (e.g PNA, PTX, CHF, PE, SVC syndrome) can be initiated.

- If the patient is hypoxemic, supplemental oxygen may provide some relief
- If the patient is not hypoxemic, air blowing over the face (fan, open window) can be as effective as O_2
- Opioids are a mainstay of treatment for dyspnea and the end of life. A reasonable starting dose would be morphine elixir 2.5 to 5 mg po q4 hours prn
- The patient should be assessed for anxiety, which can cause or be caused by dyspnea. Dyspnea will be very difficult to treat unless anxiety is also controlled.

DEATH RATTLE

This is a common sound at the end of life, often very distressing to families. It is caused by the pooling of secretions in the oropharynx, and can be treated and prevented with:

- 1% atropine ophthalmic soln. (1-2 drops SL q1-2h prn) or glycopyrrolate (0.2-0.4 mg IV q4h prn)
- Scopolamine patch 1.5 mg, apply to skin q3 days

FATIGUE

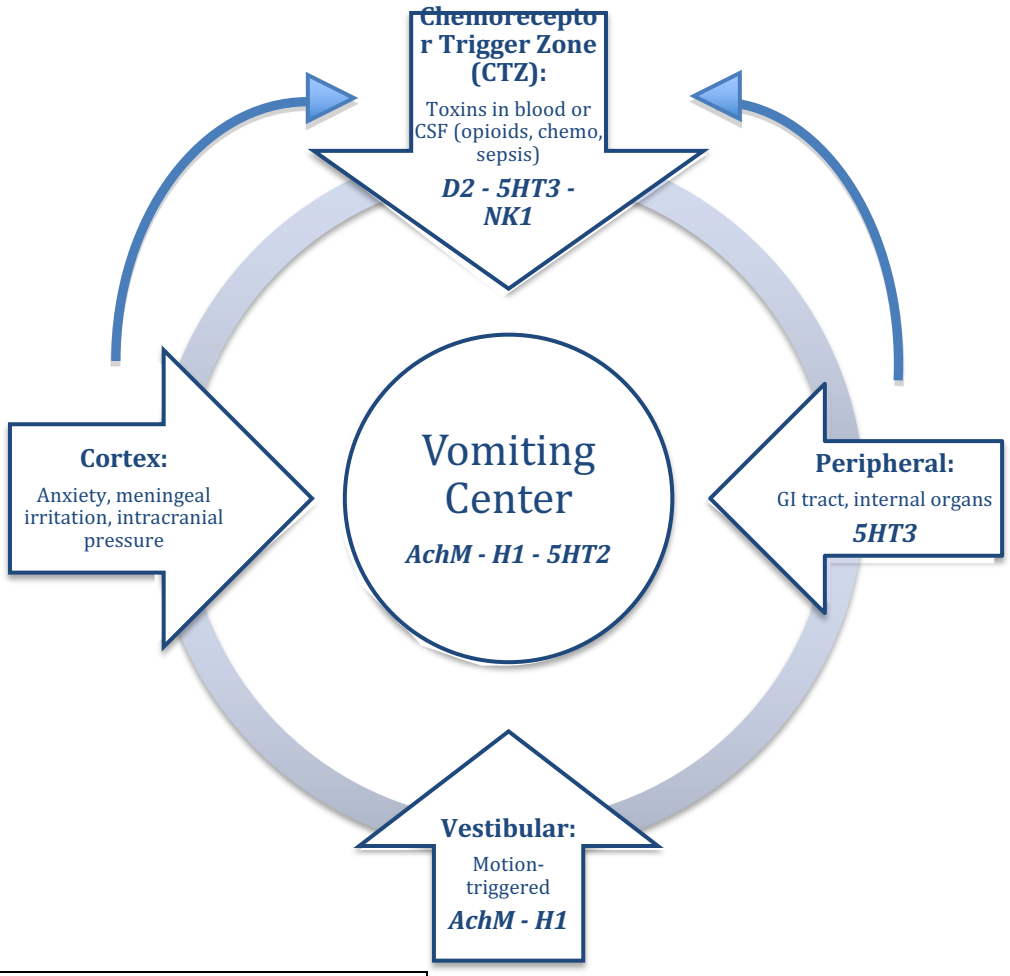
Fatigue is very common in patients with advanced illness, especially metastatic cancer. Promoting physical activity is near always the mainstay of treatment. However, being mindful of side effect profiles and comorbidities, either Modafinil (starting 5mg BID in the morning and at noon) or (if prognosis is in the range of weeks) dexamethasone (4mg BID in the morning and at noon) may be considered in the treatment plan.

NAUSEA/VOMITING

See Next page

NAUSEA AND VOMITING

Vomiting Center – control center in brain (medulla), coordinates output of vomiting



4 Major Receptors
D2 = Dopamine
H1 = Histamine
5HT3
M/Ach = Muscarinic/Acetylcholine

Clinical Pearls:

- By using medications that target these four receptors, you are covering all causes of nausea!
- To maximize effectiveness and avoid side effects, try not to combine drugs targeting the same receptor. Mix it up!

Wood GJ, Shega JW, Lynch B, Von Roenn JH. Management of Intractable Nausea and Vomiting in Patients at the End of Life"I Was Feeling Nauseous All of the Time . . . Nothing Was Working". *JAMA.* 2007;298(10):1196-1207.

Pharmacologic management of nausea

- Medications target 4 main receptors (see table below)
- **When using multiple antiemetics, makes sure you are *targeting different receptors with each medication***. This will maximize effectiveness and reduce side effects.

Receptor	Medications (w/starting doses)	Side effects	Most useful for…
Dopamine (D2)	**Metoclopramide (Reglan)** 5-10mg PO q6hr PRN **Haloperidol (Haldol)** 0.5-2mg PO q6hr PRN **Prochlorperazine (Compazine)** 5-10mg PO q6hr PRN **Olanzapine** 5-10mg daily (or BID)	Dystonia, akathisia, QTc **Caution with reglan in renal failure*	Opioid induced N/V, malignant bowel obstruction
5HT3	**Ondansetron (Zofran)** 4-8mg PO q4-8hrs PRN	Headache, fatigue, constipation, QTc	Chemo and radiation induced N/V
Histamine (H1)	**Promethazine (Phenergan)** 12.5-25mg PO q6hr PRN **Benadryl** 25-50mg PO q6hr PRN	SEDATION, Anti-cholinergic A/E, overall"messy" drug	Only use for severe, refractory nausea
Muscarinic/Ach	**Scopolamine** 1.5mg transdermal	Dry mouth, blurred vision, urinary retention, confusion	Motion triggered sickness
Centrally acting (mechanism unclear)	**Dexamethasone*** 4mg-8mg PO daily **Ativan** 0.5-1mg q6-8hrs PRN (Weak anti-emetic)	Steroids – mood swings, hyperglycemia Ativan - sedation	Steroids – brain tumors, refractory N/V Ativan – "Anticipatory" nausea

*Dex is preferred over other steroids (less mineralocorticoid activity). No need to dose BID.

Syndrome Of Imminent Death

David E Weissman MD

Fast Fact #3, 2009: https://www.capc.org/fast-facts/3-syndrome-imminent-death/

Background: Virtually all dying patients go through a stereotypical pattern of symptoms and signs in the days prior to death. This trajectory is often referred to as "actively dying" or "imminent death". Prompt recognition of this trajectory is key for clinicians to provide the most appropriate interventions for both the patient and family.

1. Stages

Early

- Bed bound
- Loss of interest and/or ability to drink/eat
- Cognitive changes: increasing time spend sleeping and/or delirium (see Fast Fact #1)

Middle

- Further decline in mental status to obtundation (slow to arouse with stimulation; only brief periods of wakefulness)
- Death rattle – pooled oral sections that are not cleared due to loss of swallowing reflex

Late

- Coma
- Fever – usually from aspiration pneumonia
- Altered respiratory pattern – periods of apnea, hyperpnea, or irregular breathing
- Mottled extremities

2. Time Course

The time to traverse the various stages can be less than 24 hours or as long as ~14 days. Patients who enter the trajectory who are nutritionally intact, with no infection (e.g. acute stroke), are apt to live longer than cachectic cancer patients

3. Common Family Concerns

Family members present during the dying process often express the following concerns/questions. Clinicians can best help families by expecting these questions, providing education and reassurance (see also Fast Fact #149).

- Is my loved one in pain; how would we know?
- Should I/we stay by the bedside?
- Aren't we just starving my loved one to death?
- Can my loved one hear what we are saying?
- What should we expect; how will we know that time is short?
- What do we do after death?

4. Treatment

- Confirm treatment goals; recommend stopping treatments that are not contributing to comfort – pulse oximetry, IV hydration, antibiotics, finger sticks, etc.
- Communicate clearly to others what is going on. Write in progress notes: "patient is dying," not "prognosis is poor".
- Treat symptoms/signs as they arise: common among these are: oral secretions (see Fast Fact #109); delirium (Fast Fact #1, Fast Fact #60); dyspnea (Fast Fact #27) and pain (Fast Fact #53, Fast Fact #54).
- Provide excellent mouth and skin care.
- Provide daily counseling and support to families.

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The FICA Spiritual History Tool

Christina Puchalski MD

Fast Fact #274: https://www.capc.org/fast-facts/274-fica-spiritual-history-tool/

Background: Spirituality is defined as "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" (1). Taking a spiritual history is an important patient assessment skill (2), and most American patients report they want medical professionals to be aware of the importance of religion or spirituality to them. Fast Fact #19 presents one approach to taking a spiritual history. This Fast Fact discusses the FICA Spiritual History Tool©.

Spirituality & Health

There is a large body of evidence that demonstrates a relationship between spirituality, religion and healthcare outcomes (3,4,5,6,7,8,9). Spirituality and religion are strong contributors to how people cope with illness and suffering (10,11,12). Providing for spiritual and religious needs benefits both patients and the health care system (13).

Spiritual History & the Healthcare Team

A National Consensus Conference (NCC) developed models and guidelines for interprofessional spiritual care (1). While the conference highlighted the importance of board-certified or board-eligible chaplains as the spiritual care experts and essential members of palliative care and other care teams, it recommended that all members of the health care team be responsible for addressing patients' spiritual issues within the biopsychosocialspiritual framework (14). The NCC recommended that all patients should have a spiritual screening or history, that spiritual distress should be diagnosed and attended to, and that validated assessment tools should be used.

Taking a Spiritual History – Key Principles

- Consider spirituality as a potentiality important component of every patient's life. Spirituality can impact a patient's quality of life; it is an inherent part of most people's wellbeing.
- Address spirituality at each new visit, at annual examinations, and at follow-up visits if appropriate.
- Respect a patient's privacy regarding spiritual beliefs.
- Be aware of your own beliefs; don't impose your spiritual/religious beliefs on others.
- Make referrals to chaplains, spiritual directors, or community resources as appropriate.

FICA

The FICA Spiritual History Tool© was developed to help healthcare professionals address spiritual issues with patients. FICA serves as a guide for conversations in the clinical setting. It is also used to help identify spiritual issues patients face, spiritual distress, and patients' spiritual resources of strength. Healthcare professionals are encouraged not to use the FICA tool as a checklist, but rather to rely on it as a guide to aid and open the discussion to spiritual issues.

F - Faith, Belief, Meaning

Do you consider yourself spiritual or religious? Do you have spiritual beliefs that help you cope with stress? If the patient responds No, the health care provider might ask, *What gives your life meaning?* It is important to contextualize these questions to the reason for the visit – e.g., wellness, stress management, breaking bad news, the end of life. Meaning might be found in family, career, nature, arts, humanities or other spiritual, cultural or religious beliefs and practices.

I - 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? If so, are you willing to share those with your healthcare team?

C – Community

Are you 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/Action in Care

How should I address these issues in your healthcare? This is also to remind clinicians to develop a plan to address patient spiritual distress or other spiritual issues.

More information and educational materials about FICA are available at http://www.gwish.org/.

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