Peer Review File

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Reviewer A

Overall, this is a well-written and articulated set of standards. It addresses a critical gap, and suggests competencies that would improve spiritual care. I have a few comments for authors to consider: 1. In the abstract, there is a small spelling error. "Por" is used rather than "for."

Thank you for your comment. We have changed the appropriate spelling in the abstract.

2. Throughout the article, spiritual care specialists are referenced. I believe it would strengthen the manuscript to discuss the differences between spiritual care specialists and generalists. The word chaplain is never used and may be useful.

Thank you. Based on the reviewer comments we have added in the introduction the following paragraph.

Spiritual care generalists must have basic training in spiritual care to be able to identify any spiritual crisis/need, to complete a spiritual history and do basic spiritual care interventions (such as compassionate presence, listening and/or refer to a Spiritual care specialist).

A spiritual care specialist (in many countries referred as Chaplain) is a person that has received specialized training and carries out a deeper assessment of spiritual needs and resources and creates a plan of care that includes spiritual interventions. The word Chaplain in Spanish means "Capellan", a term used to describe mainly a priest serving his faith community outside the walls of a church (prison, hospital, convent). Therefore, for the Latin American context, in this document we used the term Spiritual Care specialist or Spiritual Care Professional instead of word chaplain.

Would you offer any suggestions for spiritual care generalists to know the limitations of their abilities?
Thank you for your question. We have added a paragraph in the Introduction as follows:

…It is important for the team members to know themselves and be able to recognize when a spiritual care specialist is needed. Whenever spiritual care generalists find spiritual distress related to conflicted belief systems, or beliefs systems that affect the decision making process, loss of faith, concerns about meaning and purpose of life, conflicts with God or the church

dogma, or feeling guilt and fear, abandonment, and anger at God, or concerns about hopes, values, or need of religious services, a spiritual care specialist/professional needs to be called.

3. In line 144, the term "neo-Christian" is used. This is a controversial term, and could be interpreted as offensive to practitioners in this community. I would suggest not defining these religions under this term.

Thank you for your comment. We have changed the term "neo-Christians" for "Other" Christians in Introduction.

4. One of the suggestions is for spiritual growth for practitioners. This term may seem foreign or less applicable to people who do not identify as religious. You may want to consider defining spiritual growth, or further explaining it in terms of spiritual connection.

Thank you for your comment. We have modified the following paragraph in Competency 1 as follows:
Recognizing that one's own spirituality, that allow us to have continuous Spiritual growth (which includes the entire human experience in the search for meaning and purpose and connections with themselves and others, and is not limited to religion) plays an important role in one's professional life and the need to develop it using appropriate self-reflection tools in one's professional practice.

5. Authors may benefit from explaining why self care is a component of spiritual care.

Thank you for your comment. We have modified the following paragraph in Competency 1 as follows:

1.3 Recognizing the importance of self-care as conscious acts to stay physically, emotional and spiritually balanced and connected with ourselves and with others and the continuous development of self-awareness and self-reflection allows one to avoid one's own fears, prejudices, and limitations that create barriers to care and maintaining an attitude of critical reflection regarding one's clinical spiritual care practice.

6. At times, it seems like the competencies may be far-reaching and addressing culturally competent care, or compassionate care rather than solely spiritual care. While spirituality can encompass these components, it may be worth further explaining why these issues fall under spiritual care. The same points are made multiple times, and authors might consider drawing more

information into the discussion section so it does not just repeat the points made in the introduction and results section.

Thank you for your comment. We have added the following paragraph in Discussion as follows:

Clinical spiritual care is centered on and directed by patients and caregivers. Clinicians must become competent in the care of patients and caregivers with the different ethnic, cultural, and religious groups in their local areas and identify the various values, cultural aspects, and specific spiritual and religious preferences and integrate them into the care plan (9,44). Therefore, the team has an ethical obligation to establish adequate relationships with patients and caregivers through a compassionate presence and attentive listening, respect their beliefs, and accept their decision to reject any type of spiritual support that does not meet their needs (9).

Reviewer B

This is well-structured recommendations from experts. However, spiritual care is largely influenced by cultural, societal and regional backgrounds.
#1. Therefore, I recommend that authors include something specific to reflect characteristics of Latin America for six competencies in more detail.

Thank you for your comment. We included in our introduction some of the different aspects the cultural and spiritual and religious diversity in Latin America as follows. Considering the wide variety of cultural, spiritual and religious aspects in each region of Latin America, we believe that this important point will need to be addressed in future documents as more data and development in this field occur in our context.

There is an important diversity in cultural, spiritual and religious aspects among teams in Latin America, as well as in their many clinical practices. Thus, having spiritual care competencies defined as “integrated pieces of knowledge, skills and attitudes that can be used to carry out a professional task successfully" (19) can improve the practices of care teams, alleviate the spiritual suffering of people living with debilitating advanced or terminal chronic illnesses and of their caregivers, improve the relationships of patients and/or caregivers with clinicians, and improve job satisfaction and decrease burnout among team members (Fig. 1).

#2. Future readers may would like to know characteristics (particular belief for spirituality or concept of good death traditionally...) more In Introduction part.

Thank you for your comment. We included in our **introduction** some of the different aspects the cultural and spiritual and religious diversity in Latin America. We believe that this important point will need to be addressed in future documents as more data and development in this field occur in our context.

Latin America is rich in religious and spiritual diversity, and this must be considered when providing quality spiritual care to patients living with advanced or terminal illnesses, and those approaching death, as well as to their caregivers.

Another important part of Latin America's religious diversity is its indigenous native spiritual and religious practices. Latin America has more than 800 indigenous groups (some in voluntary isolation and others in large urban settings) with a total population of close to 45 million people characterized by wide demographic, social, territorial, and political diversity (33). Other important spiritual/religious traditions that may impact health care and end-of-life care include African traditions (e.g., Umbanda, Santeria, Candomblé), Judaism, Baha'i, and Islam (34–37).

#3. For Discussion part, please address what are challenges (major barriers in policies and lay persons' prejudice or medical reimbursement..) for implicating current recommended competencies in Latin America.

Thank you for your comment. In our discussion we included the following paragraphs that highlighted challenges and development of leadership spirituality in Latin America. We believe that this important point will need to be addressed in future documents as more data and development in this field occur in our context.

The importance of spiritual care in palliative care highlights the importance of developing leadership capacity in the field of spirituality and to promote this field among all health professionals and administrators (7,24). Spiritual care leadership is necessary to continue the implementation of general and professional spiritual care by teams, strengthen the spiritual care research environment, and improve evidence-based education on spiritual care in all disciplines.

In carrying out spiritual care activities, the team must recognize and respect the different spiritual, religious, and cultural traditions of its own members. Furthermore, health care professionals must be aware of their own cultural and religious beliefs and values. This awareness is necessary to minimize the possibility that prejudices, or personal preferences interfere with the interprofessional and caregiving relationships among people who have different values or beliefs (7,9,20).

Reviewer C

First, I think this paper concerns a very relevant topic: spiritual care at the end of life on a continent, where there is a shift in religious affiliation, and therefore challenges health care teams to reassess the way they want to address them.
1. BACKGROUND: In this part of the paper the religious diversity and changing spirituality and religiousness of people from Latin America and the challenges of healthcare teams to assess and address spiritual needs is adequately described.
I would be an important addition if the authors would conclude the introduction with clearly stating what their aim is in this study.

Thank you for your comment. In Introduction we have modified the following paragraph stating clearly the aim of this manuscript.

There is an important diversity in cultural, spiritual and religious aspects among teams in Latin America, as well in their many clinical practices. Thus, having spiritual care competencies defined as "integrated pieces of knowledge, skills and attitudes that can be used to carry out a professional task successfully" (19) can improve the practices of care teams, alleviate the spiritual suffering of people living with debilitating advanced or terminal chronic illnesses and of their caregivers, improve the relationships of patients and/or caregivers with clinicians, and improve job satisfaction and decrease burnout among team members (Fig. 1). **Herein the purpose of this paper is to provide to Palliative Care Teams the competencies required for High quality spiritual care in the Latin America setting, with relevant observable behaviors related to each competency and clinical implications of care that are applicable to members of the team.**

2. Possibly, the definition that is employed in this paper could also be a part of the introduction.

Thank you for your comment. We have moved the definition of spirituality to the **Introduction** section as follows:

To facilitate the adoption of a common language for spiritual care, the following definition of spirituality proposed by the National Consensus Project for Quality Palliative Care (9) was used: "spirituality is defined as the dynamic and intrinsic aspect of humanity that relates the way individuals seek and express meaning and purpose, and the way they experience their connection with the moment, with themselves, with others, with nature, and with the significant or sacred." This is the most widely used definition in the international literature

on spiritual care in palliative care. Moreover, spirituality is used as a broad term that encompasses the transcendental, religious, and existential needs of patients and caregivers.

3. Maybe the authors could consider to show figure 1 further in the paper, possibly in the results section, because the competencies that are shown in this figure are developed in this study.

Thank you for your comment. We have added the Figure 1 also as part of results as follows:

Results: We identified six core competencies of quality clinical spiritual care in Latin America: 1) personal, spiritual, and professional development; 2) ethics of spiritual care; 3) assessment of spiritual needs and spiritual care interventions; 4) empathic and compassionate communication; 5) supportive and collaborative relationships among the interdisciplinary team; and 6) inclusivity and diversity **(Figure 1).**

4. METHODS: This part of the study is unclear to me: what research method is employed?
On page 5 line 193 the authors write about a 'final step in this process'. Was it a step-by step process, because the first steps are not clearly pointed out for me.
Methodically: is it a focus group study in which the participants have discussed the literature in different steps? Or was it a Delphi study, in which step by step different literature and competencies were discussed, and step by step consensus was reached about the competencies and the components in the competencies? Or did they employ
This section should be described more clearly, because the method underpins the results.

Thank you for your comment. In Methods we have clarified the method used in this paper as follows:

As a first step in the development of the Competencies in Spiritual Care in Latin America, in 2018, members of different disciplines founded the Spirituality Commission of the ALCP **(one spiritual care specialist, seven palliative care physicians, one palliative care nurse, two psychologists, one hospice care leader and one volunteer and care coordinator for pediatric palliative care)**. One of the main objectives of this commission was to introduce and promote quality spiritual care (assessment, interventions, and follow-up) as part of the comprehensive care provided to patients in the palliative care setting and their caregivers (41). **Through continuing education and the inclusion of people with expertise in spiritual care, based on focus group process, the Spirituality Commission created important guidelines for incorporating spiritual care in palliative care and improving the quality of spiritual care provided by teams in Latin American countries**. To improve the quality of spiritual care, promote opportunities for spiritual formation that align with the international recommendations and experiences and facilitate the development of research projects that reflect the perspectives and needs of the Latin American population, a common vocabulary for spiritual care in clinical practice (Table 1) and

quality standards for general quality spiritual care for team members (Table 2) were provided by our group (10,18).
Based on these first guidelines, our focus group study discussed the literature in different steps and relevant competencies in quality spiritual care were identified and adapted to the Latin America setting through a consensus process with clinical spiritual care leaders…

5. I would also consider placing pg 5 line 168-178 in the introduction.
Thank you for your comment. We have move part of this paragraph into Introduction as follows:

There is an important diversity in cultural, spiritual and religious aspects among teams in Latin America, as well in their many clinical practices. **Spiritual care has been provided by palliative care teams through different experiences in Latin American countries.** Thus, having spiritual care competencies defined as "integrated pieces of knowledge, skills and attitudes that can be used to carry out a professional task successfully" (19) can improve the practices of care teams, alleviate the spiritual suffering of people living with debilitating advanced or terminal chronic illnesses and of their caregivers, improve the relationships of patients and/or caregivers with clinicians, and improve job satisfaction and decrease burnout among team members (Fig. 1).

6. RESULTS: In almost every first part of the competencies there is a reference to the literature. I think the competencies are derived from these papers? Competence 2 comprises aspects of 'Ethics of Spiritual Care', and there are no references. I am familiar with the concept of Ethics and the concept of Spiritual Care, for me the concept of 'Ethics in Spiritual Care' needs to be enlightened, as well as how the components of this Competency relate to the components mentioned.

Thank you for your comment: We have modified the following paragraph in Competence 2 and added the reference.

The ethics of spiritual care describes the duty to respect human life in all of its manifestations from the moment of conception to death **according to the principles of autonomy, substituted judgement, beneficence and non-maleficence. Following these principles** in each of its interactions and interventions, the team should respect the human condition and the dignity of every person. This respect for life is inextricably linked with acceptance of the vulnerability and essential fragility of each person, especially during the trajectory of a life-threatening illness **(9).**

7. There are no references for Competency 5. May I suggest the pioneering work of the ISPEC Group led by prof Christina Puchalski and dr Betty Ferrell?

Thank you for your comment: We have modified the following paragraph in Competence 2 and added the reference.

Supportive and collaborative relationships among the interdisciplinary team members define the team's ability to create and maintain collaborative and mutually committed relationships with one another and with administrative staff, external organizations, and community partners to provide quality spiritual care **(13-16, 22).**

8. Maybe as a concluding part of this section the authors can describe how they developed the model that is presented in figure 1?

Thank you for your comment. We included the description of the model in which figure 1 was created.

… having spiritual care competencies defined as "integrated pieces of knowledge, skills and attitudes that can be used to carry out a professional task successfully" (19) can improve the practices of care teams, alleviate the spiritual suffering of people living with debilitating advanced or terminal chronic illnesses and of their caregivers, improve the relationships of patients and/or caregivers with clinician and improve job satisfaction and decrease burnout among team members (Fig. 1).

9. DISCUSSION: In this section of the paper the authors present the way they aim to employ the competencies and barriers they expect along the way. I hope the authors will add a paragraph on recommendations for future research and implementation.

Thank you for your comment. We have added in the last paragraph of Discussion the following:

Our hope is that this article will mark the beginning of not only a conversation about but also an action plan toward integrating and adopting high standards in spiritual care for all health care teams in Latin America and **also developing high quality research about different aspects of spirituality, considering different cultural, social, and religious expressions, impact decision making, quality of life, symptom expression, and coping mechanisms.**

Reviewer D

Congratulations on this paper which will be an important resource for healthcare workers.
1. Introduction: The identification of both general and specialized spiritual care at the outset is very helpful. In view of the varied religiosity in Latin America, I believe it would be helpful to clearly define what spirituality in the healthcare context means in your Introduction, as well as spiritual care, instead of just having them in the Methods section.

Thank you for your comment. We have moved the definition of spirituality to the Introduction section as follows:

To facilitate the adoption of a common language for spiritual care, the following definition of spirituality proposed by the National Consensus Project for Quality Palliative Care (9) was used: "spirituality is defined as the dynamic and intrinsic aspect of humanity that relates the way individuals seek and express meaning and purpose, and the way they experience their connection with the moment, with themselves, with others, with nature, and with the significant or sacred." This is the most widely used definition in the international literature on spiritual care in palliative care. Moreover, spirituality is used as a broad term that encompasses the transcendental, religious, and existential needs of patients and caregivers.

2. You also need to add at least a sentence outlining the extent of spiritual needs in the palliative care context.

Thank you for your comment. In the section of Clinical Spiritual Care in Palliative Care: Latin American Context, we included:

At the same time, patients living with advanced illnesses have a high prevalence of spiritual distress (52-67%), which causes worsening of emotional distress, coping strategies, and quality of life (24,31). Among these vulnerable populations, 60% reported that their spiritual/religious needs had not been supported by their clinical teams (24).

3. Methods: Could you please provide more information on how you developed a common vocabulary and quality standards for general spiritual care? (Lines 180-181) Who is included in the commission (Line 170ff)? What is their expertise? How did you decide on the vocabulary/standards/competencies? Please provide more information on the PROCESS you used, not just what you ended up with.

Thank you for your comment. In Methods we have clarified the method used in this paper as follows:

As a first step in the development of the Competencies in Spiritual Care in Latin America, in 2018, members of different disciplines founded the Spirituality Commission of the ALCP **(one spiritual care specialist, seven palliative care physicians, one palliative care nurse, two psychologists, one hospice care leader and one volunteer and care coordinator for pediatric palliative care).** One of the main objectives of this commission was to introduce and promote quality spiritual care (assessment, interventions, and follow-up) as part of the comprehensive care provided to patients in the palliative care setting and their caregivers (41). **Through continuing education and the inclusion of people with expertise in spiritual care, based on focus group process,** the Spirituality Commission created important guidelines for incorporating spiritual care in palliative care and improving the quality of spiritual care provided by teams in Latin American

countries. To improve the quality of spiritual care, promote opportunities for spiritual formation that align with the international recommendations and experiences and facilitate the development of research projects that reflect the perspectives and needs of the Latin American population, a common vocabulary for spiritual care in clinical practice (Table 1) and quality standards for general quality spiritual care for team members (Table 2) were provided by our group (10,18).
Based on these first guidelines, our focus group study discussed the literature in different steps and relevant competencies in quality spiritual care were identified and adapted to the Latin America setting through a consensus process with clinical spiritual care leaders…

4. Results: it is helpful to have your definitions of each competency as well as the identifying features. **Thank you for your comment.**

5. Discussion: It would be interesting if you could compare your competencies with those developed in other jurisdictions.

Thank you for your comment: We included in Introduction a paragraph comparing with other jurisdictions. We believe that this important point will need to be addressed in future documents as more data and development in this field occur in our context.

In addition, we must recognize that most of the research in spirituality and spiritual care is performed in North America and Europe, which leaves a great knowledge gap concerning spiritual care in the cultural and social context of Latin America. The ability to design and implement spiritual care research projects in one's own cultural context is an important part of clinicians' professional development (24–26).

6. Line 413ff there is also evidence that skill in spiritual care reduces staff burnout eg Girgis 2009.

Thank you for your comment: In competency 1, we included a paragraph about the importance of recognizing burnout as part of spiritual care as follows:

Recognizing the signs of burnout syndrome, compassion fatigue, and chronic stress in oneself and others and activating established protocols within the team to address these issues (20, 47).
Establishing an ongoing plan to nurture one's own spirituality, compassionate presence, and self-reflective capacity (20).

7. Line 433 Spiritual care training in other jurisdictions enables healthcare workers to provide spiritual support of patients regardless of their own belief system. Please add this aspect of training

to make it clear that the carer and the patients do not have to share the same belief system in order for care to be provided.

Thank you for your comment. We have modified the following paragraph in Discussion:

Clinicians must become competent in the care of patients and caregivers with the different ethnic, cultural, and religious groups in their local areas and identify the various values, cultural aspects, and specific spiritual and religious preferences and integrate them into the care plan (9,44). Therefore, the team has an ethical obligation to establish adequate relationships with patients and caregivers through a compassionate presence and attentive listening, respect their beliefs, and accept their decision to reject any type of spiritual support that does not meet their needs (9).

8. While you discuss the difference between generalist and specialist spiritual carers in the Introduction, I find it is not clearly differentiated in the Discussion. In other areas, the issue of when a generalist should refer to a specialist spiritual car provider is an essential part of the competency needed.

Thank you. Based on the reviewer comments we have added in the introduction the following paragraph.

Spiritual care generalists must have basic training in spiritual care to be able to identify any spiritual crisis/need, to complete a spiritual history and do basic spiritual care interventions (such as compassionate presence, listening and/or refer to a Spiritual care specialist).

A spiritual care specialist (in many countries referred as Chaplain) is a person that has received specialized training and carries out a deeper assessment of spiritual needs and resources and creates a plan of care that includes spiritual interventions. The word Chaplain in Spanish means "Capellan", a term used to describe mainly a priest serving his faith community outside the walls of a church (prison, hospital, convent). Therefore, for the Latin American context, in this document we used the term Spiritual Care specialist or Spiritual Care Professional instead of word chaplain.

Finally, it would be helpful to identify that lack of generalist training has been a major barrier to provision of spiritual care in other jurisdictions, and that organized introduction of training to meet these competencies would be required.

Thank you for your comment. We included the following paragraph in Discussion:

One of the most common barriers to providing quality spiritual care is discomfort of health care professionals when initiating conversations about spirituality (11,12,14,59– 61). Being able to effectively communicate the scope and benefits of spiritual care in the context of health care is essential for helping patients and caregivers understand and accept this type of care. All team members should know how to explain the basic concepts of spiritual care (e.g., describing the difference between spirituality and religion) and initiate a general dialogue to identify basic spiritual needs and resources (25,49,62).

Also, in Discussion

Also, we recognize that given the different settings in which palliative care is provided in Latin America, not all teams will be able to develop these competencies in a short period. Our hope is that this article will mark the beginning of not only a conversation about but also an action plan toward integrating and adopting high standards in spiritual care for the benefit of all health care teams and for the high-quality care of patients and caregivers in Latin America. At the same time, to help developing high quality educational programs and research about different aspects of spirituality, considering different cultural, social, and religious expressions, impact decision making, quality of life, symptom expression, and coping mechanisms in our region.
A native English speaker needs to check the manuscript.
Thank you for your comment. Our team of scientific editors has checked our manuscript.

Reviewer E

This project and paper are important contributions to palliative care literature. The authors have created a resource that draws from the existing evidence-base for spiritual support in palliative care and highlights cultural nuances of the Latin American context. I recommend that this paper be accepted for publication with minor revisions.
1. Introduction: Line 79 – what are the "same duties" as other team members that is referenced? Is there a source for this?

Thank you for your comment: We included the paragraph in Introduction describing the duties of the Spiritual Care Specialist/Professional and the reference, as follows:

The spiritual care specialist/professional is a member of the team with the same duties and rights as other team members which includes assuring his/her professional suitability, access to medical records, adequate compensation, and continuing education opportunities (9).

9. National Consensus Project for Quality Palliative Care. Clinical Practical Guidelines for Quality Palliative Care, 4th edition. [Internet]. Richmond, VA; National Coalition for Hospice and Palliative Care; 2018 [cited 2022 Apr 7]. Available from: https://www.nationalcoalitionhpc.org/ncp.

2. Line 89 – The paper mentions agnostic/atheist in at least two places which does not capture a separate group which is known in the United States as "spiritual but not religious." This designation is very common in the US – would it apply to Latin America as well?

Thank you for your comment. In the context of Latin America, the concept of being "Spiritual but not Religious" is not commonly used, therefore we do not mention it in our manuscript.

3. Methods: Line 218 – Competency 1 – Team members recognizing the impact of their own beliefs, attitudes and preferences is certainly an important part of quality palliative care, as evidence by the multiple consensus guidelines cited in this section to support this recommendation. Are there existing resources that provide guidance to palliative care professionals about how to accomplish this and/or be held accountable in this pursuit?

Thank you for your comment. We included in Competency 1, the following behaviors to help professionals to accomplish part of this competency. We believe that this important point will need to be addressed in future documents as more data and development in this field occur in our context.

1.2. Recognizing that one's own spirituality, that allow us to have continuous Spiritual growth (which includes the entire human experience in the search for meaning and purpose and connections with themselves and others, and is not limited to religion) plays an important role in one's professional life and the need to develop it using appropriate self-reflection tools in one's professional practice.

1.3. **Recognizing the importance of self-care as conscious acts to stay physically, emotional and spiritually balanced and connected with ourselves and with others and the continuous development of self-awareness and self-reflection allows one to avoid one's own fears, prejudices, and limitations that create barriers to care and maintaining an attitude of critical reflection regarding one's clinical spiritual care practice.**

4. Line 257 – What about ethics in post-mortem care, e.g. beyond death? This is important in several faith traditions, e.g. the care of the body after death.

Thank you for your comment. In Competency 6 we included the following behavior to cover this important topic.

6.5. Evaluating and addressing the cultural aspects of end-of-life care, including cultural rituals and beliefs related to the dying process, death and after death.

5. Line 283 – Regarding Competency 3 in general, the ability to recognize spiritual needs, resources and interventions is informed by evidence-based tools. Although the references provide examples, I believe this competency would be strengthened by a suggestion that palliative care providers be aware of tools that have demonstrated effectiveness, rather than using their own untested strategies for spiritual screening, history and assessment.

Thank you for your comment. We included as a part of Discussion of competency 3 the following paragraph:

Health care professionals should adopt and implement structured and validated instruments of spiritual assessment to facilitate the documentation of spiritual needs and evaluate the outcomes of spiritual interventions (7,9,21,23,42). We recognize also that tools used in other countries will need to be validated in the Latin American context.

6. Line 361 – What does training in the subject entail? Is there a source that could bring more context/guidance about what this looks like?

Thank you for your comment: we have modified the following paragraph in Competency 5:

Each palliative care team should include a professional who is responsible for providing and coordinating spiritual care. If a spiritual care specialist/professional or spiritual counselor is not available, this role can be temporarily assumed by a member of the team who is fully trained in the competencies for high quality spiritual care, as described in this document.

7. Line 387 – Regardless of diagnosis seems appropriate to philosophy of palliative care, but also at diagnosis.

Thank you for your comment and very important point. We included in our Competency 3 the importance of spiritual care in the continuum of care during the illness, since diagnosis, as follows:

Competency 3.2: “Identifying, evaluating, and documenting the spiritual needs and resources that arise **throughout the course of an illness”**

Discussion: Line 407 – Again, the recommendation for palliative care providers to "accept our own vulnerability and spiritual needs" is an excellent recommendation and positively impacts palliative care – but what guidance exists about effective tools and existing resources to assist with this? Similarly, Line 417 regarding addressing burnout. Perhaps my question is beyond the scope of the paper but perhaps the authors can acknowledge that more concrete guidance is needed for clinicians in these areas?

Thank you for your comment. We believe that this important point will need to be addressed in future documents as more data and development in this field occur in our context.

Also, in Discussion we modified the following paragraph:

Also, we recognize that given the different settings in which palliative care is provided in Latin America, not all teams will be able to develop these competencies in a short period. Our hope is that this article will mark the beginning of not only a conversation about but also an action plan toward integrating and adopting high standards in spiritual care for the benefit of all health care teams and for the high quality care of patients and caregivers in Latin America, and also developing high quality research about different aspects of spirituality, considering different cultural, social, and religious expressions, impact decision making, quality of life, symptom expression, and coping mechanisms.

Reviewer F

Overall, this article is written very well. Assisting clinicians and non-clinicians as part of the interdisciplinary team in understanding the importance of generalist spiritual care and how to implement this into practice, versus that of specialist spiritual care, is so important. I commend all authors on this fabulous work! Below are some editing suggestions to consider:

1. In abstract: change "competencias por" to the English equivalency (i.e. competencies for) for continuity of language presentation (if appropriate)

   Thank you for your comment. We have changed the appropriate spelling in the abstract.

2. Line 20: change word "significance" to "significant"
   Thank you for your comment. We have changed word "significance" to "significant"

3. Line 130: Italicize the title of the work discussed
   Thank you for your comment. We have italicized the title of the work discussed as follows:

According to a report titled ***Religion in Latin America: Widespread Change in a Historically Catholic Region*** by the Pew Research Center in 2014 (32),

4. Line 158: Include the page number for the direct quote (reference #9)

Thank you for your comment. We have added the page number of the reference 9.

9. National Consensus Project for Quality Palliative Care. Clinical Practical Guidelines for Quality Palliative Care, 4th edition. [Internet]. Richmond, VA; National Coalition for Hospice and Palliative Care; **2018:32-35** [cited 2022 Apr 7]. Available from: https://www.nationalcoalitionhpc.org/ncp.

5. Consider removing all gendered language for more inclusivity (i.e. "his or her"- change to "they").
Thank you for your comment. Throughout the manuscript we have tried to use an inclusive language.

6. Line 375: Remove the word "of" between the words "sociocultural" and "factors".

Thank you for your comment. The word “of” has been removed in the paragraph of Competency 6 as follows:

Inclusivity and diversity describe the ability to recognize the sociocultural factors relevant to the patient, caregivers, team, and clinical institution that influence treatment and care throughout the course of an illness and are essential to creating an inclusive environment that is respectful of differences observed in our population (9,40,44–46).

7. Line 408: Delete the second "our".
Thank you for your recommendation. We have deleted the second “our” and now the paragraph reads as follows:

Accepting our own vulnerability and spiritual needs allows us to improve the quality of our compassionate presence and listening in clinical encounters and recognizing that our own self-care is essential to provide quality spiritual care is important.

8. Line 409: Delete the period (".") before "recognizing" to continue the sentence.

Thank you for your recommendation. We have deleted the period and modified by sentence as follows, in Discussion:

Accepting our own vulnerability and spiritual needs allows us to improve the quality of our compassionate presence and listening in clinical encounters **and recognizing that our own self-care is essential to provide quality spiritual care is important.**

9. Line 458: Consider re-writing the sentence starting with, "Although such..." to make more sense (possibly: "serve to guide spiritual screening")?

Thank you for your recommendation. We have modified the following paragraph as follows:

Although such screening tools serve to guide spiritual screening, there is need to validate them and proof their effectiveness in the Latin America context.

10. Line 505: Remove comma (,) after "Also".

Thank you for your recommendation. We have modified the following paragraph as follows:
Also important is facilitating patients' and caregivers' access to pastors, religious leaders, and traditional healers in their community.

11. Line 543: Add a period (.) after "Latin America"

Thank you for your recommendation. We have modified the following paragraph as follows:

We recognize that this article is not without limitations. To the best of our knowledge, this is the first published article on competencies regarding the quality of spiritual care in Latin America.