The content is extremely important. Conversations with patients/consumers require preparation, empathy, and scientific content. Carefully designed interventions need a strategy to enhance outcomes.

The abstract is missing.Please construct an abstract and keywords.

There are solid references for the overall content of the manuscript
However, some – a lot- of the content appears to be taken from AI and no academic citations are included. These situations need to be rectified.

Example of AI content that is not cited appropriately - Guidance specific to breaking bad news by video has emphasized the need for preparation, clear signaling, empathic presence, and deliberate pacing—practices that are consistent with both RCC and trauma-informed principles.
This appears to have been cut and pasted from an AI source. Appropriate academic citations and paraphrasing are needed. This is a direct quote, and there are no quotation marks.
Another example of statements taken directly from AI content that has not been analyzed and paraphrased or cited with the actual academic source: Accrediting bodies are increasingly recognized as vital in driving the adoption of **trauma-informed, relationship-centered communication** within medical education, moving beyond traditional, less rigorous assessment methods. The integration of these competencies requires moving away from self-reporting toward observed, high-stakes practice
A substantial amount of content in this manuscript is from AI and does not incorporate needed citations. This may be considered plagiarism.

I am concerned that with this second manuscript, I now am more aware that AI is being used, and critical analysis and use of source materials has been neglected.
AI does assist us in clarifying the issues of using AI: "misrepresentation, erosion of scholarly integrity, and breakdown of citation integrity" (Committee on Publication Ethics). Perhaps there should be more instruction in the author's guidelines that require AI transparency- how it is used and urge critical analysis and original thinking.
The section on **Accreditation and Professional Standards** could include an example of reflective supervision or suggestions for handling serious diagnoses with cultural sensitivity and or multicultural resources that address cultural dynamics.

The section on **Reimbursement and Time Structures** or the section **on Equity & Social Welfare** could identify whether any organization has an exemplary policy that can be used as guidance. For example, there is the SPIKES protocol which is relevant because it provides a replicable structure for delivering serious diagnoses with attention to emotion and patient understanding. The authors could note whether this is a good example or not of the issues they are concerned about.

Key Sources:

Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kudelka, A. P. (2000). SPIKES—A six-step protocol for delivering bad news: Application to the patient with cancer. The *Oncologist*, 5(4), 302–311.

Ptacek, J. T., & Eberhardt, T. L. (1996). Breaking bad news: A review of the literature. *JAMA,* 276(6), 496–502.

These sources also offer examples that can be considered and supported or rejected:

Bernacki, R. E., & Block, S. D. (2014). Communication about serious illness care goals: A review and synthesis of best practices. JAMA Internal Medicine, 174(12), 1994–2003.

Paladino, J., Bernacki, R., Neville, B. A., et al. (2019). Evaluating an intervention to improve communication between oncology clinicians and patients with life-limiting cancer. JAMA Oncology, 5(6), 801–809.

Green, B. L., Saunders, P. A., Power, E., et al. (2015). Trauma-informed medical care: Patient response to a primary care provider communication training. Journal of Loss and Trauma, 20(2), 147–159.

Shared decision-making policies can also be useful in designing ways to implement improved communications:

Elwyn, G., Frosch, D., Thomson, R., et al. (2012). Shared decision making: A model for clinical practice. *Journal of General Internal Medicine,* 27(10), 1361–1367.

Stacey, D., Légaré, F., Col, N. F., et al. (2017). Decision aids for people facing health treatment or screening decisions. *Cochrane Database of Systematic Reviews*

I agree that patient satisfaction surveys are inadequate in gathering consumer feelings and preferred interactions. More research is needed in this area, but there are sources that address respect for identity and absence of assumptions or stereotypes by clinicians. Perhaps the authors can suggest or locate some questions or related research that garners the kind of information needed to improve personal respect and cultural sensitivity in the health system communication process.