Point-by-Point Response to Editor and Reviewer Comments

Reviewer / Editor Comment (Verbatim)	Author Response
"Thank you for your revised submission. Reviewer 2 is fully satisfied and recommends acceptance.	Thank you
Reviewer 1 acknowledges the substantial improvements made but has identified several points requiring attention before the manuscript can be accepted:	Thank you
Editor Comments	
Terminological consistency: Please ensure that the concepts announced in the revised title (Beliefs, Knowledge, Experiences) are used consistently throughout the abstract, introduction, and results. Terms such as attitudes and practices (pp. 6–7) should be reconciled with this framing.	We thank the editor for highlighting this important issue. In the revised manuscript, we have conducted a thorough review of the abstract, introduction, results, and discussion to ensure consistent use of the constructs explicitly stated in the title—beliefs, knowledge, and experiences. Instances where the terms *attitudes* and *practices* appeared (previously on pp. 6–7) have now been replaced with the title-aligned terminology
Multi-level structure of questionnaire items: The reviewer notes that items appear to assess perceptions at individual, organizational, and societal levels. Please clarify this explicitly in the text, or consider reorganizing items to better reflect these dimensions.	We agree with this observation and appreciate the opportunity to clarify. The revised manuscript now explicitly states that the questionnaire assessed perceptions across multiple levels, including individual (e.g., self-assessed knowledge and confidence), organizational (e.g., institutional pain management adequacy), and societal/professional contexts (e.g., community-level opioid misuse). This clarification has been added to both the Methods and Results sections. Additionally, we revised the introductory text for Tables 2 and 3 to explicitly reference these levels, thereby improving conceptual alignment between questionnaire items and their analytic presentation.
Introduction coherence (lines 133–138, p. 7): Please strengthen the transition leading into this key argumentative	In response, we have revised the paragraph preceding lines 133–138 to provide a clearer narrative progression. Specifically, we now more explicitly

passage, particularly regarding training stages and practice settings.	articulate how differences in training stage (residents vs. attending physicians) and practice setting contribute to variability in pain management beliefs and experiences. This strengthened transition better frames lines 133–138 as the central rationale for the study and enhances overall coherence in the Introduction.
Sample description: Please maintain a clear and consistent distinction between attending physicians and residents throughout the manuscript, rather than relying solely on the umbrella term "approximately 500 physicians."	We have revised the manuscript to consistently refer to all physicians as clinicians throughout all relevant sections, including the Abstract, Methods, Results, and Discussion and to explicitly highlight that we compared the perceptions of attending physicians and resident physicians. We have also highlighted that clinicians can either be attending physicians, residents or fellows.
Likert scale justification: Please provide a brief methodological rationale for the concurrent use of 5-point and 7-point scales."	Thank you for this helpful suggestion. We have revised the Methods section to explicitly justify the use of different Likert scale lengths. Briefly, scale selection was construct-driven: a 7-point scale was used for more abstract belief- and knowledge-related items to allow greater response granularity and sensitivity, while a 5-point scale was used for institution-specific, experience-based items to reduce respondent burden and align with common formats used in organizational and health services research. We have clarified that scale formats were consistent within each item set and that items using different scales were analyzed separately, thereby minimizing any measurement concerns.
Reviewer 2	
Thanks for the opportunity to review your paper and for comprehensively addressing the comments. No further changes recommended.	Thank you
Reviewer 1 Comments	
However, some inconsistency remains in the use of concepts in relation to the	We thank Reviewer 1 for this careful reading. As noted above, we have

revised title (Beliefs, Knowledge and Experiences). In the abstract, as well as in certain additions to the introduction (and occasionally in the results), terms such as beliefs, perceived knowledge, and confidence are used, whereas elsewhere the manuscript refers to attitudes and practices (pp. 6–7). It may be helpful to ensure greater terminological consistency and to more clearly define the concepts under study. I also remain somewhat uncertain about the constructs actually being measured based on the questionnaire items. For example: “Prescription opioid misuse is a major problem in my community” reflects a perception of a public health issue (societal level) ? “I feel that I have adequate training in pain management” reflects a perception of competence (individual level) ? “Chronic pain is well managed at this institution” reflects a perception of quality of care (organizational level) ?	comprehensively revised the manuscript for terminological consistency, ensuring that all constructs explicitly map onto beliefs, knowledge, or experiences.
While all of these items relate to perceptions, they appear to target distinct objects across different levels (individual, societal/professional, and organizational). It may be useful to clarify that the items assess perceptions at multiple levels in relation to pain management and opioid use. Alternatively, reconsidering their organization could help better reflect these dimensions (for example, by more clearly distinguishing individual versus organizational perceptions, as seems to be partially done in Tables 2 and 3).	We appreciate this insightful observation. In response, we have added explicit clarification that the instrument measures perceptions related to pain management and opioid use across multiple analytical levels (individual, organizational, societal). This clarification is now included in the Methods section and reiterated in the Results narrative. We believe this explicit framing resolves ambiguity regarding construct measurement and strengthens the conceptual transparency of the study.
	As suggested, we have chosen the first approach by clearly stating that the items assess perceptions at multiple levels. We also refined the organization and textual framing of Tables 2 and 3 to better reflect these dimensions, thereby enhancing

	interpretability without altering the underlying questionnaire structure.
In the introduction, lines 133–138 (p. 7) appear to represent the core of the argument. However, the preceding paragraph does not seem to lead into this section as clearly as it could. A more explicit articulation of ideas, particularly regarding stages of training and practice settings, could improve the overall coherence.	We agree and have revised the preceding section of the Introduction to more explicitly foreground variability by training stage and practice setting. This revision strengthens the logical progression into lines 133–138 and clarifies why this population-specific assessment is both necessary and timely.
Further minor clarification is also needed regarding the sample. The statement “approximately 500 physicians” appears to include both attending physicians and residents; maintaining this distinction explicitly throughout the manuscript would enhance clarity, as is done on pages 11 and 12.	This comment aligns with the editor’s observation. We have now consistently used the term clinicians which includes residents, fellows and attending physicians) and then when appropriate and needed distinguished between attending physicians and residents throughout the manuscript, including in descriptive statistics, tables, and interpretive commentary.
From a methodological standpoint, the rationale for using both 5-point and 7-point Likert scales would benefit from further elaboration.	As noted above, we have revised the Methods section to explicitly justify the use of different Likert scale lengths. Briefly, scale selection was construct-driven: a 7-point scale was used for more abstract belief- and knowledge-related items to allow greater response granularity and sensitivity, while a 5-point scale was used for institution-specific, experience-based items to reduce respondent burden and align with common formats used in organizational and health services research. We have clarified that scale formats were consistent within each item set and that items using different scales were analyzed separately, thereby minimizing any measurement concerns.
Finally, I particularly appreciated the following statement in the introduction to the conclusion, which clearly reflects the study’s intent and contribution: “This study provides a cross-sectional assessment…” This passage effectively highlights the	We thank Reviewer 2 for their positive evaluation and confirmation that the revised manuscript satisfactorily addresses prior concerns.

scope of the work.	
Thank you for this thoughtful contribution.	We appreciate the positive feedback and suggestions.