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REVIEWER'S REPORT

Manuscript No.: IJAR-58682

Title: Knowledge, Attitude, and Practice of Medication Reconciliation among Pharmacy Interns in Jeddah, Saudi Arabia: A Cross-Sectional Study,

Recommendation:
Accept as it is .....
Accept after minor revision.....
Accept after major revision ...YES.....
Do not accept (*Reasons below*) .....

Rating	Excel.	Good	Fair	Poor
Originality			☐	
Techn. Quality				☐
Clarity			☐	
Significance		☐		

Reviewer's ID: JPR-094

Detailed Reviewer's Report

 # Reviewer Report

Overall Assessment

This manuscript addresses an important and clinically relevant topic concerning medication reconciliation (MedRec) competency among pharmacy interns. The focus on pharmacy interns in Saudi Arabia is potentially valuable because medication reconciliation is an important component of medication safety and transition-of-care services. The study uses a cross-sectional KAP design, an established questionnaire, appropriate non-parametric statistical tests, and reports an interesting association between formal MedRec training and KAP scores.

However, several substantial methodological, statistical, interpretational, and reporting issues need to be addressed before the manuscript can be considered for

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publication. In particular, the sample size is considerably below the calculated requirement, convenience sampling limits generalizability, the questionnaire requires stronger validation evidence, and the unexpected finding of lower KAP scores among trained interns is interpreted too speculatively. The manuscript also needs to distinguish its novelty more clearly from previous Saudi Arabian MedRec KAP studies.

1. Strengths of the Manuscript

1. **Clinically important topic: Medication reconciliation is directly related to medication safety, prevention of medication discrepancies, and quality of care during transitions.**

2. **Relevant study population: Focusing on pharmacy interns is valuable because interns represent the future pharmacy workforce and may participate in medication reconciliation during clinical practice.**

3. **Relevant geographical context: Data from Jeddah, Saudi Arabia provide potentially useful regional information for pharmacy education and internship-program development.**

4. **Clear study objective: The manuscript clearly identifies KAP assessment and examination of associations with gender, clinical rotation, and formal MedRec training as its major objectives.**

5. **Ethical approval is reported: The authors provide an ethics approval number and state that informed consent was obtained.**

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6. **Appropriate basic statistical approach: Because the authors report non-normal distributions, use of medians, IQRs, Mann–Whitney U tests, and Spearman correlation is generally appropriate.**

7. **Interesting finding: The significantly lower KAP scores among interns reporting formal training is an important finding that deserves investigation, although its interpretation requires considerable revision.**

8. **Practical implications: The recommendation for structured, simulation-based and supervised MedRec training has potential relevance to pharmacy education and internship-program development.**

9. **Limitations are acknowledged: The authors appropriately recognize the cross-sectional design, self-reported practice, single-centre setting, inadequate sample size, and high non-response for one item.**

 # 2. Major Weaknesses / Methodological Concerns

2.1 Sample size is substantially inadequate

The authors calculated a required sample size of **143, but only **93 interns** participated. Therefore, the achieved sample is considerably below the planned sample.**

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This raises concerns about statistical power, particularly for subgroup analyses. The non-significant findings for gender and clinical rotation completion may represent insufficient statistical power rather than true absence of associations.

****Recommendation:**** **The authors should provide a post-hoc discussion of statistical power and clearly emphasize that subgroup non-significance should not be interpreted as evidence of equivalence.**

2.2 Convenience sampling limits generalizability

Participants were recruited using convenience sampling from a ****single institution, King Abdulaziz University**.**

The manuscript sometimes makes conclusions regarding pharmacy interns in Jeddah or Saudi Arabia generally, although the study population represents only one institution.

****Recommendation:**** **Conclusions should be restricted primarily to the studied population. Claims regarding Saudi pharmacy interns nationally should be substantially moderated.**

2.3 Questionnaire validity requires better documentation

The questionnaire is described as "validated," but the manuscript states that it was adapted from a previously published instrument and subsequently face-validated by three experts.

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Face validation by three experts does **not establish comprehensive psychometric validity.**

There is no information regarding:

*** internal consistency/reliability;**
*** Cronbach's alpha;**
*** construct validity;**
*** criterion validity;**
*** test-retest reliability;**
*** validation of the adapted version specifically in pharmacy interns.**

****Recommendation:** The authors should clearly distinguish between the validity of the original questionnaire and validation performed for the present study. Reliability analysis should be reported if appropriate.**

2.4 The scoring system is unusual and requires justification

Each item is reportedly scored:

*** Yes = 9**
*** Don't Know = 5**
*** No = 1**

with 10 items producing a score from 10–90.

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This scoring system is unusual, particularly for knowledge assessment. The manuscript needs to explain why these numerical values were selected and whether they originate directly from the validated instrument.

More importantly, the interpretation of a median score of 22/90 as "poor knowledge" requires a **predefined classification system.**

****Recommendation:** Provide the source and justification for the scoring system and define the thresholds used for "poor," "moderate," and "good" KAP.**

2.5 The interpretation of the training result is too speculative

The most striking finding is:

*** Knowledge: trained 9 vs untrained 23**
*** Attitude: trained 10 vs untrained 31**
*** Practice: trained 17 vs untrained 41**

with statistically significant differences.

The authors attribute this to the Dunning–Kruger effect, conscious competence, and potentially inadequate training.

However, the study did not measure:

*** quality of training;**
*** duration of training;**
*** training content;**

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*** timing of training;**

*** trainer qualifications;**

*** practical versus theoretical training;**

*** pre-training KAP;**

*** post-training KAP.**

Therefore, the manuscript **cannot conclude that the training was inadequate or superficial.**

The association could result from selection bias, reverse causation, differences in internship exposure, self-selection into training, or other unmeasured confounding variables.

****Recommendation:** The Dunning–Kruger explanation should be presented only as a hypothesis rather than an explanation established by the data.**

2.6 The statement that "current training fails to build competence" is too strong

The conclusion states that current training is failing to build clinical competence.

The study is cross-sectional and observational. It does not compare participants before and after training.

Therefore, the authors cannot establish training effectiveness or failure.

****Recommendation:** Replace causal language with wording such as:**

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> "Formal MedRec training was unexpectedly associated with lower KAP scores in this sample; further longitudinal research is required to determine whether this reflects differences in training quality, participant characteristics, or self-assessment."

2.7 Very high non-response for K9 needs clarification

The manuscript reports that **77.4% of participants did not respond to the question regarding the MedRec form.**

This is a very high missing-data proportion and could substantially influence the knowledge-domain interpretation.

The authors interpret this as evidence of unfamiliarity with MedRec tools, but non-response could also arise from:

*** questionnaire design;**
*** ambiguous wording;**
*** technical problems;**
*** participants being unsure how to answer;**
*** respondents skipping the question.**

****Recommendation:** Explain exactly how missing responses were handled statistically and why non-response was interpreted as lack of knowledge.**

2.8 Clinical rotation variable is highly imbalanced

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Only **8 participants (8.6%) had completed clinical rotations, compared with 85 who had not.**

A comparison between groups of 8 versus 85 is statistically unstable and has limited ability to detect meaningful differences.

****Recommendation:** The authors should explicitly identify this as a major limitation and avoid strong conclusions regarding clinical rotation.**

2.9 Self-reported practice does not represent actual practice

The study assesses **self-reported MedRec practice, not observed clinical performance.**

Therefore, the manuscript should avoid equating the Practice score with actual clinical competence.

****Recommendation:** Clearly distinguish "self-reported practice" from objectively assessed MedRec performance.**

 # 3. Key Points Requiring Revision

A. Clarify the novelty

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The manuscript should explain more explicitly how this study differs from previous MedRec KAP studies in Saudi Arabia, particularly the Hussain et al. study cited as reference 12.

The authors should clearly state:

*** why pharmacy interns were selected;**
*** what new information this study provides;**
*** how the current questionnaire differs from the previous instrument;**
*** whether the population and setting are substantially different;**
*** whether any participants overlap with previous research.**

B. Improve statistical reporting

The manuscript should report, where possible:

*** exact p-values rather than only "NS";**
*** effect sizes;**
*** confidence intervals;**
*** sample sizes for every analysis;**
*** missing-data handling;**
*** reliability statistics for the KAP instrument.**

C. Consider multivariable analysis

Because several demographic and training variables are available, the authors could consider whether an adjusted analysis is feasible.

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However, given the small sample and very small clinical-rotation subgroup, the authors should avoid overfitting.

D. Correct the wording of conclusions

The conclusion should not imply that training caused poor KAP.

The data demonstrate an **association, not causation.**

E. Improve presentation and language

There are numerous formatting and typographical problems, for example:

*** "transitionsadmission, transfer, and discharge"**
*** "participants predominantly"**
*** "high-quality educational componentmodelled"**
*** "training appears"**
*** "201920199"**
*** "15:2471" in the final reference**
*** duplicated and incomplete reference information.**

The manuscript requires thorough English-language and reference-format editing.

 # 4. Scientific Significance

The study has **moderate scientific and educational significance.**

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Its greatest potential contribution is identifying a possible gap between pharmacy-intern education and practical medication-reconciliation competency. The finding that only approximately one-third of interns reported formal MedRec training also has potential implications for pharmacy curriculum design.

The study may be particularly useful to:

*** pharmacy educators;**
*** internship-program coordinators;**
*** clinical pharmacy departments;**
*** medication-safety committees;**
*** healthcare accreditation bodies;**
*** policymakers involved in pharmacy education in Saudi Arabia.**

However, the scientific impact is currently limited by the small sample, single-centre design, convenience sampling, self-reported practice measurement, and cross-sectional methodology.

 # 5. Key Novelty / Key Findings

The potentially novel aspects of the study are:

1. Assessment of MedRec KAP specifically among pharmacy interns in Jeddah.
2. Identification of substantial self-reported gaps in MedRec knowledge, attitude, and practice.

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3. Demonstration of a strong positive association between attitude and self-reported practice (rho = 0.591).

4. Identification of an unexpected inverse association between reported formal MedRec training and KAP scores.

5. Identification of a substantial gap in practical familiarity with MedRec tools.

6. Potential implications for structured MedRec training within pharmacy internship programs.

The inverse association with training is particularly interesting but should be treated as a **hypothesis-generating observation, not evidence that training is harmful or ineffective.**

 # 6. Minor Issues

1. The abstract should use consistent terminology for "formal training."

2. Define exactly what constituted formal MedRec training.

3. Report the characteristics of the training received by the 30 trained participants.

4. Explain why two participants did not answer the training question.

5. Correct the inconsistency between "validated questionnaire" and "face-validated questionnaire."

6. Provide the complete questionnaire as supplementary material if permitted.

7. Clarify whether the 10 pilot participants were from the same internship cohort.

8. Provide details of the normality test used.

9. Clarify whether correction for multiple comparisons was considered.

10. Ensure all tables are formatted consistently.

11. Correct reference formatting and incomplete bibliographic information.

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12. Verify all DOI information.

13. Ensure that all claims about CBAHI requirements are supported by the correct current standard.

14. Avoid overgeneralization from one Saudi institution to the entire country.

15. Improve English grammar, spacing, punctuation, and formatting throughout.

 # 7. Overall Recommendation

**Recommendation: Major Revision**

The manuscript addresses an important and relevant issue and contains potentially useful findings. The study has reasonable structure, ethical approval, a clearly defined research question, and potentially meaningful implications for pharmacy education and medication safety.

However, **major revision is required before publication.**

The principal reasons are:

*** inadequate achieved sample size (93 versus 143 required);**

*** convenience sampling and single-centre design;**

*** insufficient evidence for validation/reliability of the adapted questionnaire;**

*** unusual KAP scoring system requiring justification;**

*** very high missing data for an important knowledge item;**

*** extremely small clinical-rotation subgroup;**

*** reliance on self-reported practice;**

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*** overinterpretation of the unexpected training-related finding;**

*** unsupported inference that current training is superficial or ineffective;**

*** insufficient differentiation from previous Saudi MedRec research;**

*** several language, formatting, and reference errors.**

Final Reviewer Judgment

****Scientific relevance:** Good**

****Originality:** Moderate**

****Methodological quality:** Moderate to weak**

****Statistical analysis:** Generally appropriate but requires strengthening**

****Clinical/educational significance:** Good**

****Presentation quality:** Requires substantial improvement**

****Ethical reporting:** Satisfactory**

****Current publishability:** Not suitable in present form**

****Recommended decision:** **MAJOR REVISION****

If the authors adequately address the methodological limitations, clarify the questionnaire and scoring system, moderate the causal interpretations, strengthen the novelty statement, and improve statistical and reporting quality, the manuscript could become a useful contribution to the literature on pharmacy education and medication reconciliation.

Below is a **line-by-line Major Revision justification that you can use directly in a reviewer report. I have focused on the specific manuscript lines and given the **issue + reason + required correction**.**

 # Major Revision Justification: Line-by-Line Reviewer Comments

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****Manuscript Title:****

****Knowledge, Attitude, and Practice of Medication Reconciliation among Pharmacy Interns in Jeddah, Saudi Arabia: A Cross-Sectional Study****

Recommendation: MAJOR REVISION

The manuscript addresses an important and potentially publishable topic. However, substantial methodological, statistical, interpretational, and presentation issues must be addressed before the manuscript can be considered for publication.

A. Abstract

Lines 5–7 – Introduction

****Issue:** The statement that pharmacy-intern preparedness for medication reconciliation in Saudi Arabia is "understudied" is insufficiently supported.**

****Reason:** Previous Saudi Arabian studies have already examined medication-reconciliation knowledge, attitudes, practices, and pharmacy-intern involvement. Therefore, the authors need to establish the precise research gap rather than broadly stating that the topic is understudied.**

****Required revision:** Clearly identify what is novel about the present study, particularly its specific population, institution, geographical setting, questionnaire, and outcomes.**

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Lines 8–10 – Aim

****Issue:** The aim is appropriate but includes several variables despite the relatively small sample.**

****Reason:** With only 93 participants, subgroup analyses involving gender, clinical rotation, and training may have limited statistical power.**

****Required revision:** Clearly identify the primary outcome and distinguish it from exploratory secondary associations.**

Lines 11–14 – Methods

****Issue:** The questionnaire is described as "validated," but the manuscript does not establish adequate validation for the adapted version.**

****Reason:** The questionnaire was adapted from another study and only face-validated by three experts. Face validation alone does not establish reliability or construct validity.**

****Required revision:** Clarify the original instrument's validation, describe the adaptation process, and provide reliability/psychometric evidence for the present instrument if available.**

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Lines 15–20 – Results

****Issue:** The interpretation of KAP scores as "poor" is not sufficiently justified.**

****Reason:** No validated cut-off points for poor/moderate/good KAP are provided.**

****Required revision:** Provide the source and criteria used to classify KAP levels.**

Lines 17–20 – Training result

****Issue:** The finding that trained interns had significantly lower KAP scores is highly unusual and requires cautious interpretation.**

****Reason:** A cross-sectional comparison cannot establish whether training caused lower KAP scores. Reverse causation, selection bias, differences in training quality, timing, or baseline characteristics may explain the association.**

****Required revision:** Replace causal interpretation with "associated with" and present possible explanations as hypotheses.**

Lines 21–24 – Conclusion

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****Issue:** The statement that current education and training has significant gaps is stronger than the evidence supports.**

****Reason:** The study did not evaluate training quality or conduct pre- and post-training assessments.**

****Required revision:** Limit the conclusion to an observed association and recommend longitudinal/interventional studies to assess training effectiveness.**

Lines 25–27 – Impact Statement

****Issue:** The statement that the findings directly inform national workforce development strategies is excessive.**

****Reason:** The study is single-centre, uses convenience sampling, and includes only 93 interns.**

****Required revision:** Restrict implications primarily to pharmacy education and internship-program development, with national implications described as potential rather than direct.**

 # B. Introduction

Lines 31–35 – Medication errors

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****Issue:** General statements regarding medication errors and economic burden are broad.**

****Reason:** The claims should be directly supported by current and appropriately cited evidence.**

****Required revision:** Ensure that every epidemiological and economic claim is accurately supported by the cited source.**

Lines 34–35 – Formatting

****Issue:** "Care transitionsadmission, transfer, and dischargerepresent..." contains serious formatting errors.**

****Reason:** Missing spaces/em dashes reduce readability and indicate inadequate manuscript preparation.**

****Required revision:** Correct to appropriate wording, e.g., "Care transitions—admission, transfer, and discharge—represent..."**

Lines 40–45 – International standards and outcomes

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****Issue:** The statement regarding accreditation mandates and reductions in hospital revisits/ED visits needs more precise citation.**

****Reason:** The manuscript combines regulatory standards and outcome data in a manner that may imply direct causation.**

****Required revision:** Separate regulatory statements from clinical outcome evidence and verify that reference [6] supports the exact percentages reported.**

Lines 46–54 – Research gap

****Issue:** The claim that data specific to pharmacy interns are "largely absent" appears too broad.**

****Reason:** Previous studies have examined pharmacy interns and medication-reconciliation activities in Saudi Arabia.**

****Required revision:** Perform a more comprehensive literature review and explicitly distinguish the current study from previous Saudi pharmacy-intern research.**

Lines 55–60 – Theoretical framework

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****Issue:** The manuscript introduces Social Cognitive Theory and Theory of Planned Behavior but does not adequately integrate these frameworks into the study methodology.**

****Reason:** Merely mentioning theoretical models does not establish their application.**

****Required revision:** Explain how the questionnaire domains correspond to the theoretical constructs and how the theories guided the study hypotheses.**

Lines 60–63 – "Validated model"

****Issue:** The phrase "validated model for evaluating clinical readiness" is potentially misleading.**

****Reason:** KAP methodology is not automatically a validated measure of clinical readiness, and self-reported practice does not directly measure clinical competence.**

****Required revision:** Avoid equating KAP scores with objective clinical readiness unless appropriate validation evidence is provided.**

 # C. Methods

Lines 70–71 – Study setting and period

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****Issue:** The study is limited to one institution.**

****Reason:** A single-centre study substantially limits external validity.**

****Required revision:** Clearly define the setting and limit generalization accordingly.**

Lines 73–77 – Participant recruitment and sample size

****Issue:** The calculated sample size was 143, but only 93 participants were included.**

****Reason:** The final sample represents a substantial shortfall from the planned sample and may have resulted in inadequate statistical power.**

****Required revision:** Explain why recruitment stopped at 93 and discuss the impact on statistical power and precision.**

Lines 76–77 – Convenience sampling

****Issue:** Convenience sampling introduces selection bias.**

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****Reason:** Participants who chose to participate may differ systematically from interns who did not participate.**

****Required revision:** Explain recruitment procedures, response rate, and potential selection bias.**

Lines 79–86 – Questionnaire

****Issue:** The questionnaire is described as validated, although the current version was adapted and only face-validated.**

****Reason:** Adaptation can alter measurement properties.**

****Required revision:** Provide detailed information regarding questionnaire development, adaptation, expert validation, pilot testing, and reliability.**

Lines 82–84 – Scoring system

****Issue:** The scoring system of Yes = 9, Don't Know = 5, and No = 1 is unusual.**

****Reason:** The numerical distance between response categories may imply assumptions about measurement that require justification.**

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****Required revision:** Explain the origin and psychometric justification of this scoring system and provide the original source.**

Lines 83–84 – KAP classification

****Issue:** The manuscript labels scores as "poor" without providing validated thresholds.**

****Reason:** A score of 22/90 does not automatically establish "poor knowledge."**

****Required revision:** Provide predefined cut-offs or report the scores without categorical labels if validated thresholds do not exist.**

Lines 84–86 – Face validation

****Issue:** Only three clinical pharmacy experts performed face validation.**

****Reason:** Face validation is insufficient to establish content, construct, or internal validity.**

****Required revision:** Report content-validity procedures and reliability analysis where appropriate.**

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Lines 85–86 – Pilot study

****Issue:** The pilot involved only 10 interns.**

****Reason:** A small pilot may assess comprehension but cannot provide robust psychometric validation.**

****Required revision:** Clearly describe the pilot as a readability/comprehension assessment rather than full validation.**

Lines 87–88 – Variables

****Issue:** Important details regarding "formal MedRec training" are missing.**

****Reason:** Training may vary considerably in duration, content, delivery method, and timing.**

****Required revision:** Define formal training and report its duration, content, mode, timing, and provider.**

Lines 90–95 – Statistical analysis

****Issue:** The statistical analysis is relatively limited.**

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****Reason:** Only unadjusted Mann–Whitney U tests and correlations were performed, despite several potential confounding variables.**

****Required revision:** Consider an appropriate multivariable analysis if sample size permits. If not, explain why adjusted analysis was not performed.**

Lines 91–92 – Normality testing

****Issue:** The specific normality test is not reported.**

****Reason:** The choice of non-parametric analysis should be transparently justified.**

****Required revision:** Name the normality test used and report relevant statistics.**

Lines 92–94 – Multiple comparisons

****Issue:** Multiple hypothesis tests were conducted.**

****Reason:** Multiple testing increases the possibility of false-positive findings.**

****Required revision:** State whether adjustment for multiple comparisons was considered and justify the approach used.**

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 # D. Results

Lines 103–105 – Participant characteristics

****Issue:** The sample is highly homogeneous.**

****Reason:** 96.8% were Saudi nationals and only 3.2% were non-Saudi.**

****Required revision:** Discuss how this demographic composition affects generalizability.**

Lines 104–105 – Clinical rotation

****Issue:** Only 8 participants had completed clinical rotation.**

****Reason:** The comparison of 8 versus 85 participants is highly imbalanced and likely underpowered.**

****Required revision:** Treat this analysis as exploratory and avoid strong conclusions based on the non-significant result.**

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Lines 105–107 – Training data

****Issue:** There is an inconsistency in the percentages.**

****Reason:** 30 + 61 = 91, while the total sample is 93. The authors explain that two participants did not respond, but the percentages should be calculated using the appropriate denominator and clearly labelled.**

****Required revision:** Correct Table 1 and explicitly report missing responses.**

Lines 109–113 – KAP scores

****Issue:** KAP scores are labelled "poor" without established thresholds.**

****Reason:** The manuscript does not provide validated cut-offs.**

****Required revision:** Provide the classification criteria or remove categorical labels.**

Lines 113–116 – 77.4% non-response

****Issue:** The interpretation of missing responses as unfamiliarity is not necessarily justified.**

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****Reason:** Non-response may have multiple causes.**

****Required revision:** Explain why the missing responses occurred and how they were handled statistically.**

Lines 120–127 – Training comparison

****Issue:** The large difference between trained and untrained groups requires deeper analysis.**

****Reason:** The trained group may differ systematically from the untrained group in age, internship stage, clinical exposure, or other characteristics.**

****Required revision:** Provide additional baseline comparisons and, if feasible, adjusted analyses.**

Lines 120–124 – Causal implication

****Issue:** The result may be interpreted as suggesting that training is harmful.**

****Reason:** The study design cannot determine causality.**

****Required revision:** Explicitly state that the finding represents an association only.**

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Lines 128–134 – Correlation analysis

Issue: The manuscript interprets the Attitude–Practice correlation as evidence that attitude drives practice.

Reason: Correlation does not establish temporal direction or causality.

Required revision: Use "associated with" rather than "drives" or equivalent causal language.

E. Discussion

Lines 137–142 – Interpretation

Issue: The discussion occasionally generalizes findings beyond the study population.

Reason: The sample is from one institution and uses convenience sampling.

Required revision: Restrict conclusions to the study population and appropriately qualify broader implications.

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Lines 143–144 – Representativeness

****Issue:** The manuscript states that the demographic profile is broadly representative of pharmacy interns in Jeddah.**

****Reason:** No external demographic data are presented to demonstrate representativeness.**

****Required revision:** Remove or support this statement with appropriate population data.**

Lines 149–154 – Clinical rotation

****Issue:** The manuscript concludes that clinical exposure does not affect MedRec competency.**

****Reason:** Only eight participants had completed clinical rotations, making the comparison severely underpowered.**

****Required revision:** State that no significant association was detected in this small sample rather than concluding that clinical exposure has no effect.**

Lines 155–166 – Dunning–Kruger explanation

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****Issue:** The Dunning–Kruger effect is presented as the principal explanation for lower scores among trained interns.**

****Reason:** The study did not directly measure self-assessment accuracy, competence, or metacognitive ability.**

****Required revision:** Present this as one possible hypothesis and acknowledge alternative explanations.**

Lines 163–166 – Training quality

****Issue:** The manuscript claims that training in Jeddah appears inadequate or insufficiently structured.**

****Reason:** The characteristics of the training received by the 30 trained participants were not assessed.**

****Required revision:** Provide training characteristics or substantially moderate this statement.**

Lines 167–170 – K9 interpretation

****Issue:** The 77.4% non-response is treated as proof of poor practical knowledge.**

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****Reason:** Missing data cannot automatically be interpreted as incorrect knowledge.**

****Required revision:** Report the missing-data mechanism and avoid converting missing responses directly into evidence of incompetence.**

Lines 171–178 – Theory of Planned Behavior

****Issue:** The theoretical interpretation may exceed what can be inferred from simple correlations.**

****Reason:** The study did not measure all major components of the Theory of Planned Behavior, such as subjective norms and perceived behavioral control.**

****Required revision:** Present the theory as a conceptual framework rather than evidence of the proposed causal pathway.**

Lines 179–187 – Comparison with other studies

****Issue:** Comparisons with other studies are useful but sometimes imply equivalence between different study designs and populations.**

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****Reason:** The cited studies include intervention and service-delivery studies, whereas the present study is a cross-sectional KAP survey.**

****Required revision:** Clearly distinguish differences in design, population, intervention, and outcome measures.**

Lines 189–198 – Limitations

****Issue:** The limitations section is useful but should be expanded.**

****Reason:** Important limitations include convenience sampling, questionnaire adaptation, uncertain psychometric properties, highly imbalanced subgroups, potential selection bias, and inability to determine causality.**

****Required revision:** Include all major methodological limitations.**

 # F. Conclusion

Lines 200–208 – Overstatement of findings

****Issue:** The statement that "current training [is] failing to build clinical competence" is not supported by the study design.**

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****Reason:** No pre-training/post-training comparison or objective competency assessment was performed.**

****Required revision:** Change to an association-based conclusion.**

Lines 202–206 – Dunning–Kruger and inadequate training

****Issue:** The conclusion presents Dunning–Kruger and inadequate training as explanations for the observed association.**

****Reason:** Neither was directly measured.**

****Required revision:** State that these are possible explanations requiring prospective investigation.**

Lines 209–215 – Recommendations

****Issue:** The recommendation for mandatory standardized training is reasonable but stronger than the evidence directly supports.**

****Reason:** The study demonstrates an educational gap but does not test a particular intervention.**

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****Required revision:** Recommend development and evaluation of standardized training rather than implying that the proposed program has already been proven effective in this population.**

 # G. References and Presentation

Lines 219–257 – Reference problems

****Issue:** Several references contain formatting, duplication, incomplete bibliographic information, or apparent typographical errors.**

****Examples include:****

*** Line 222: duplicated/inconsistent citation information.**
*** Line 231: "201920199" appears erroneous.**
*** Line 249: "44:15-10" requires verification.**
*** Line 252: "9:027395-10" requires correction.**
*** Line 257: Reference 15 appears incomplete.**

****Reason:** Incorrect references compromise the credibility and reproducibility of the manuscript.**

****Required revision:** Verify every reference against the original publication and format all references according to the target journal's style.**

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 # Overall Major Revision Justification

The manuscript should receive **Major Revision rather than Minor Revision because the problems are not limited to grammar or presentation. They affect the **validity, interpretation, and generalizability of the study findings**.**

The most important issues requiring substantive correction are:

1. **Sample size: 93 participants versus 143 calculated.**
2. **Convenience sampling: significant risk of selection bias.**
3. **Single-centre design: limited generalizability.**
4. **Very small clinical-rotation subgroup: only 8 participants.**
5. **Questionnaire validity: adapted instrument with insufficient evidence of psychometric validation.**
6. **Unusual scoring system: requires methodological justification.**
7. **Unclear KAP cut-offs: "poor" scores are not adequately defined.**
8. **77.4% missing response to K9: interpretation as lack of knowledge is questionable.**
9. **Training paradox: lower KAP among trained interns requires additional analysis and cautious interpretation.**
10. **Causal overinterpretation: Dunning–Kruger effect and inadequate training are hypotheses, not demonstrated causes.**
11. **Self-reported practice: cannot be equated with actual clinical competence.**
12. **Theoretical framework: Social Cognitive Theory and Theory of Planned Behavior are not fully operationalized.**
13. **Novelty: the manuscript needs clearer differentiation from previous Saudi medication-reconciliation research.**

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14. **Statistical reporting: effect sizes, confidence intervals, missing-data handling, and multiple-comparison considerations should be addressed.**

15. **Reference and language problems: substantial editorial correction is required.**

Final Recommendation to the Editor

****Decision: MAJOR REVISION****

The manuscript has **good clinical relevance and potentially useful educational implications, but the current version does not provide sufficient methodological and interpretative rigor to support its stronger conclusions. The authors should undertake substantial revision, particularly regarding questionnaire validation, sample-size limitations, statistical interpretation, missing data, the unexpected training association, novelty, and causal claims.**

****The study should not be rejected solely because of the small sample or unusual training finding; however, publication should be reconsidered only after the above major methodological and interpretative concerns have been adequately addressed.****