Dear Editorial Board,

Thank you for reviewing our manuscript. We found them very useful in improving our manuscript. We have addressed your comments and made major changes accordingly. They are outlined in the resubmitted tracked changes document. Please find below point by point response to the comments:

1) The title has been revised to "Educational, psychosocial, and clinical impact of SARS-CoV-2 (COVID-19) pandemic on medical students in the United States."
2) The abstract has been revised. The aim of the study and suggestions for future research has been included.
3) Keywords have been revised to MeSH terms.
4) The background has been shorted and revised.
5) In regard to the validity and reliability of the test on medical students as the original test was performed on surgeons, only less than 30% of the questions were adopted from the survey on spine surgeons. The majority of questions were specifically designed for medical students. The questions went through several rounds of review and revision by the attendings of the medical school to verify they reliably assess the impact of COVID-19 on students.
6) Most of the studied subjects were from California, Florida, Massachusetts, Missouri, Pennsylvania, and Washington. However, we may say that those six states with the highest participants are from West, Central, and East of the USA, which somehow can represent a sample of the entire nation's students. These states are also very popular to receive students from other states, which again helps in generalizability of the results to the entire country.
7) The majority of the students participating in the survey were in their beginning four years of their studies. This highlights an additional limitation as the final two years are the clinical years and students faced dismissal from the hospital wards.
8) Regarding the grouping limitations, power of the study, and sampling plan, this study is not a randomized trial, but a semi-structured qualitative research using a survey. We cannot use the mindset as a randomized trial or an epidemiology study which has single exposure and primary/secondary hypothesis testing. The purpose of our study is to explore a possible explanation of why medical students faced stress when the COVID-19 pandemic hit. We do not have a predefined hypothesis. Therefore, it not necessary to conduct power analyses. The value of our study is timing. This kind of study can only capture information under the high impact of the pandemic when most of the administrative/governing infrastructure were shutdown. Convenience sample is the only way to go. It is impossible to have a well-planned sampling with power calculation.
9) For the code of ethics, we added an additional sentence under "compliance with ethical standards" Ethics: No identifying information was collected to ensure ethical compliance of the study. All the participants were anonymous.

10) “First, the authors dichotomize 1-10 anxiety into low (≤5) and high (>5) categories. What is the basis for this classification? Or this classification is just a subjective classification of the author. If there are no established criteria, I would recommend categorizing anxiety into three categories: low (<3.3), moderate (>3.3 & <6.6), and high (>6.6), because in previous literature on anxiety, anxiety is present Moderate, moderate levels of anxiety do not significantly affect an individual's learning.”

    We appreciate the reviewers’ suggestions. However, if we stratify our sample into three categories we are at risk of lower statistical power. We also double the amount by reporting the risk for both mid and high vs. low. Again, our main interest is to find out the characteristics and/or social exposures of those under high stress. Our anxiety scale is integer, therefore >5 is actually ≥ 6 which is consistent with the reviewer recommended >6.6. We have changed >5 to ≥ 6.
    Also, we dichotomized items in order to maximize the number of cases and improve statistical power based on a recent study (doi: 10.1080/22423982.2018.1454786). We are less interested in linear increase of stress level (stress treated as continuous measurement), but more interested in finding the characteristics and/or social exposures of those under high stress (dichotomized stress).
11) We have included a flow chart as requested by the reviewer.
12) The tables have been adjusted accordingly to the standard three-line tables.

We hope the revisions are found responsive and appropriate, and that the revised manuscript will be deemed acceptable for publication in your prestigious journal. Please do not hesitate to contact us if any further revisions are warranted.

Best Regards,

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