Date: Dec 18, 2018
To: "Julie Chor" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-18-2115

RE: Manuscript Number ONG-18-2115

A shared decision making framework for pelvic examinations in asymptomatic, non-pregnant patients

Dear Dr. Chor:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Jan 08, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: Chor and colleagues provide a commentary on shared decision making for pelvic examination in asymptomatic women. Comments for the authors:

1. In the Introduction it would be useful to briefly discuss some of the harms of routine pelvic examinations and why ACP recommends against the practice.

2. It seems inappropriate to place routine pelvic examinations into the context of the me too movement and the US Olympic gymnastics experience. Arguably, tens or hundreds of millions of pelvic examinations have been performed during well women examinations worldwide and to question the exams based on "contemporary events" like the US gymnastics physician scandal seems inappropriate and sensational.

3. Pap "smear" should be Pap test.

4. While for some patients with significant concern for pelvic exams shared decision making may be appropriate, the commentary needs to have a bit more balance. It is unrealistic to expect busy gynecologists to have a twenty minute discussion when deciding whether or not to perform a 30 second pelvic examination in every patient. This time could be much better spent counseling patients on a variety of primary medical needs. Further, there is no data that average patients are interested in a lengthy discussion of their values and preferences for a pelvic examination. Prior to recommending implementation of shared decision making for millions of women there needs to be quantifiable data that such a change in approach in someway improves outcomes or experience.

5. Shared decision making is typically employed for complex medical decisions in which each choice has defined pros and cons (lumpectomy vs. mastectomy for breast cancer). Is there data examining shared decision making for relatively minor interventions such as this?

Reviewer #2: Interesting topical research article, especially with the recent 2018 ACOG publication.
Just a few questions.

In the abstract, shared decision making is discussed in the context of pelvic examination. Was there any discussion about its' applicability to other aspects of the medical examination and the fact that it is used already frequently in many

dimensions of medicine.

On line 38, the implication is that professional organizations that do not support this notion can not be 'leading' professional organizations.?? Is that what you wish to say?

In line 166 a 4 step framework is discussed but then you identify 5 steps. Do you wish to imply that one of the paragraphs is superfluous?

Reviewer #3: Very interesting discussion of a very current and appropriate topic

line 73 - suggest "whether or not" rather than "Whether"

EDITOR COMMENTS:

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor's specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript. These comments should be included in your point-by-point response cover letter.

The notated PDF is uploaded to this submission's record in Editorial Manager. If you cannot locate the file, contact Randi Zung and she will send it by email - rzung@greenjournal.org.

- I am very interested in your take on the following: What you are describing is essentially what I was taught years ago when learning to be a doctor. I've have struggled with trying to understand the "shared decision making" model. Some who have written about this emphasize how important it is to use decision tools--that this is the distinguishing feature between discussing pros and cons and getting talking to patients about their response to those and their preferences vs shared decision making. I suspect I'm not alone in trying to figure this out and perhaps you could address this a bit more in your
paper.

- Would "undergo" be better than "Obtain"? Obtain just seems very transactional.

- how does lack of evidence result in assessment that something is potentially harmful? Couldn't it just as likely lead to potential for benefit?

- I agree with one of your reviewers. Not sure #metoo is actually relevant here. Yes, the olympic doctor's egregious behavior may be relevant. Some where above (can't find it right now) you mention that some doctors "Require" that their asymptomatic patients get a pelvic exam. I'm not sure I endorse that...that would essentially be assault if the patient didn't want it. I would also recommend that in your discussion you re-emphasize that you are really talking about exams for asymptomatic patients, although the principles would apply to any procedure.

- Ethicists commonly discuss 4 fundamental aspects of bioethics in health care--autonomy is only of these 4 (beneficence, non malfeasance, autonomy, justice). What evidence suggests autonomy is paramount?

- please define: Step-wise consent, power schange, trauma-informed care,and "debriefing" post-exam"

- what are the principle of mutuality and of voluntariness?

- The Journal style doesn't not use the virgule (/) except in numeric expressions. Please edit here and in all instances.

- what about rectal examination?

- or parts of the exam

- pelvic self-awareness seems like a parallel to the terminology of "Breast self awareness" which never seemed to be well adopted. Is pelvic self-awareness a known terminology

- aren't all dialogues bidirectional?

2. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with

efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

3. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at http://links.lww.com/AOG/A515, and the gynecology data definitions are available at http://links.lww.com/AOG/A935.

4. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Current Commentary articles should not exceed 12 typed, double-spaced pages (3,000 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and appendixes).

5. Specific rules govern the use of acknowledgments in the journal. Please edit your acknowledgments or provide more information in accordance with the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your signature on the journal's author agreement form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

6. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Current Commentary articles, 250 words. Please provide a word count.

7. Only standard abbreviations and acronyms are allowed. A selected list is available online at http://edmgr.ovid.com/ong/accounts/abbreviations.pdf. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

8. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

9. The American College of Obstetricians and Gynecologists' (College) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite College documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly. If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if a College document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All College documents (eg, Committee Opinions and Practice Bulletins) may be found via the Resources and Publications page at http://www.acog.org/Resources-And-Publications.

10. Figure 1 may be resubmitted as-is.

11. If you choose to revise your manuscript, please submit your revision via Editorial Manager for Obstetrics & Gynecology at http://ong.editorialmanager.com. It is essential that your cover letter list point-by-point the changes made in response to each criticism. Also, please save and submit your manuscript in a word processing format such as Microsoft Word.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors, that each author has given approval to the final form of the revision, and that the agreement form signed by each author and submitted

with the initial version remains valid.

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Jan 08, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

2017 IMPACT FACTOR: 4.982
2017 IMPACT FACTOR RANKING: 5th out of 82 ob/gyn journals

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THE UNIVERSITY OF CHICAGO
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
THE CHICAGO LYING-IN HOSPITAL

JULIE CHOR, MD MPH
[redacted]

December 19, 2018

Dear Editorial Board and Reviewers,

Thank you for your comments regarding our submission ONG-18-2115 ("A shared decision making framework for pelvic examinations in asymptomatic, non-pregnant patients"). We have modified the manuscript in response and address your comments in response to reviewers. Throughout this response, text in red is newly added in response to reviewers' comments and recommendations. We look forward to your comments.

Sincerely,

Julie Chor

RE: Manuscript Number ONG-18-2115

REVIEWER COMMENTS:

Reviewer #1: Chor and colleagues provide a commentary on shared decision making for pelvic examination in asymptomatic women. Comments for the authors:

1. In the Introduction it would be useful to briefly discuss some of the harms of routine pelvic examinations and why ACP recommends against the practice.

RESPONSE: Thank you for this recommendation. We have included specific potential harms posited in the ACP recommendation in this revision.

Lines: 66-9: The American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP) recommend against performing “screening pelvic examinations”, which they view as lacking supporting evidence and potentially harmful due to risks of emotional distress and unnecessary additional procedures for benign findings (2,3).

2. It seems inappropriate to place routine pelvic examinations into the context of the me too movement and the US Olympic gymnastics experience. Arguably, tens or hundreds of millions of pelvic examinations have been performed during well women examinations worldwide and to question the exams based on "contemporary events" like the US gymnastics physician scandal seems inappropriate and sensational.

RESPONSE: Reference to the #metoo movement has been removed from this revision. However, many patients are aware of and discussing recent incidents around physicians conducting rare but egregious misconduct around the pelvic examination. There have been several very public events that inform how some patients may feel about this examination. We do feel that referencing this is appropriate with attention to the rarity of such events.

Lines: 144-6: Finally, contemporary events and public discourse about exceedingly rare but egregious physician misconduct underscore the importance of endowing patients with greater agency in gynecologic care, especially around the pelvic examination.

3. Pap "smear" should be Pap test.

RESPONSE: The terminology have been modified accordingly in this revision.

Lines 171-3: While it is unlikely that a patient actually had a pap test in the emergency department and instead likely had a speculum or bimanual examination, this example illustrates a general lack of clarity about terminology.

4. While for some patients with significant concern for pelvic exams shared decision making may be appropriate, the commentary needs to have a bit more balance. It is unrealistic to expect busy gynecologists to have a twenty minute discussion when deciding whether or not to perform a 30 second pelvic examination in every patient. This time could be much better spent counseling patients on a variety of primary medical needs. Further, there is no data that average patients are interested in a lengthy discussion of their values and preferences for a pelvic

examination. Prior to recommending implementation of shared decision making for millions of women there needs to be quantifiable data that such a change in approach in someway improves outcomes or experience.

RESPONSE: We appreciate you bringing up these considerations. There is in fact data to demonstrate that women strongly desire a discussion of pros and cons prior to proceeding with a screening pelvic examination. This research is now included in the revision. Additionally, we appreciate the reviewer's concern for balance and have added a sentence expressing this caveat.

Lines: 87-9: When educated about recommendations for or against screening examinations, women overwhelmingly (94%) believe discussions of benefits and harms should precede screenings pelvic examination (8).

Lines: 231-5: While shared decision making around routine pelvic exams is appropriate for many patients, we acknowledge than in busy gynecology practices this time may be prioritized to counsel patients on a variety of primary medical needs. Research is needed to determine how to optimally integrate this counseling into clinical encounters and to potentially develop decision aids to help busy clinicians in this endeavor.

5. Shared decision making is typically employed for complex medical decisions in which each choice has defined pros and cons (lumpectomy vs. mastectomy for breast cancer). Is there data examining shared decision making for relatively minor interventions such as this?

RESPONSE: Thank you for your thoughtful comment. We have included recommendations for further research examining the use of shared decision making in this context in the conclusion section of this revision.

Lines: 233-5: Research is needed to determine how to optimally integrate this counseling into clinical encounters and to potentially develop decision aids to help busy clinicians in this endeavor.

Reviewer #2: Interesting topical research article, especially with the recent 2018 ACOG publication.
Just a few questions.

1. In the abstract, shared decision making is discussed in the context of pelvic examination. Was there any discussion about its' applicability to other aspects of the medical examination and the fact that it is used already frequently in many dimensions of medicine.

RESPONSE: Reference to the applicability and use of shared decision making in other dimensions of medicine is now included in the abstract.

Lines: 43-4: Shared decision making is a model used in other aspects of medicine that can aid such discussions.

2. On line 38, the implication is that professional organizations that do not support this notion can not be 'leading' professional organizations.?? Is that what you wish to say?

RESPONSE: Reference to “leading professional organizations” has been removed from this revision.

Lines: 40-1: However, several professional organizations support the notion that providers should no longer recommend that asymptomatic patients receive a yearly pelvic examination.

3. In line 166 a 4 step framework is discussed but then you identify 5 steps. Do you wish to imply that one of the paragraphs is superfluous?

RESPONSE: The revision has been modified to recognize that our proposed framework is a 5-step framework.

Lines: 156-8: The proposed 5-step framework adapts a framework by Stiggelbout and colleagues to discussions about whether to proceed with a routine pelvic examination (Figure 1)(12).

Reviewer #3: Very interesting discussion of a very current and appropriate topic

1. line 73 - suggest "whether or not" rather than "Whether"

RESPONSE: This language has been modified accordingly.

Lines 74-6: Both organizations determined that data on risks and benefits of performing a pelvic examination for asymptomatic, non-pregnant patients are limited. ACOG concluded that whether or not to perform this examination is a matter of clinical equipoise – there is no clear right or wrong decision.

EDITOR COMMENTS:

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor’s specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript. These comments should be included in your point-by-point response cover letter.

The notated PDF is uploaded to this submission's record in Editorial Manager. If you cannot locate the file, contact Randi Zung and she will send it by email - rzung@greenjournal.org.

1. I am very interested in your take on the following: What you are describing is essentially what I was taught years ago when learning to be a doctor. I've have struggled with trying to understand the "shared decision making" model. Some who have written about this emphasize how important it is to use decision tools—that this is the distinguishing feature between discussing pros and cons and getting talking to patients about their response to those and their preferences vs shared decision making. I suspect I'm not alone in trying to figure this out and perhaps you could address this a bit more in your paper.

RESPONSE: We agree that shared decision making includes key aspects of effective patient-provider communication that have been taught for some time in medical education. This likely reflects the shift in medical education from an emphasis on a paternalistic approach of counseling to this more egalitarian approach of shared decision making. The use of decision tools to help facilitate this model of communication can also be helpful. We have included language to address these points in this revision.

Lines 90-2: We propose shared decision making is the most patient-centered approach and a concrete tool that clinicians can incorporate with little-to-no extra training, as it incorporates key facets of patient-provider communication already familiar to many providers.

Lines 233-5: Research is needed to determine how to optimally integrate this counseling into clinical encounters and to potentially develop decision aids to help busy clinicians in this endeavor.

2. Would "undergo" be better than "Obtain"? Obtain just seems very transactional.

RESPONSE: Thank you for this recommendation. The language has been changed accordingly in this revised version.

Line 62: Over 50 million individuals undergo pelvic examinations yearly (1).

Lines 127-8: Some may have personal or family cultural beliefs that go against the idea of undergoing an invasive pelvic examination.

3. how does lack of evidence result in assessment that something is potentially harmful? Couldn't it just as likely lead to potential for benefit?

RESPONSE: Thank you for alerting us to the confusion in language. Wording has been modified for clarity in this revision.

Lines: 66-9: The American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP) recommend against performing “screening pelvic examinations”, which they view as lacking supporting evidence and potentially harmful due to risks of emotional distress and unnecessary additional procedures for benign findings (2,3).

4. I agree with one of your reviewers. Not sure #metoo is actually relevant here. Yes, the olympic doctor's egregious behavior may be relevant. Some where above (can't find it right now) you mention that some doctors "Require" that their asymptomatic patients get a pelvic exam. I'm not sure I endorse that...that would essentially be assault if the patient didn't want it. I would also recommend that in your discussion you re-emphasize that you are really talking about exams for asymptomatic patients, although the principles would apply to any procedure.

RESPONSE: **RESPONSE**: Reference to the #metoo movement has been removed from this revision. However, many patients are aware of and discussing recent incidents around physicians conducting rare but egregious misconduct around the pelvic examination. There have been several very public events that inform how some patients may feel about this examination. We do feel that referencing this is appropriate with attention to the rarity of such events. Additionally, the first paragraph of the discussion reiterates that this manuscript focuses on asymptomatic patients.

Lines: 144-6: Finally, contemporary events and public discourse about exceedingly rare but egregious physician misconduct underscore the importance of endowing patients with greater agency in gynecologic care, especially around the pelvic examination.

Lines: 214-8: This commentary responds to recommendations to use shared decision making prior to potentially performing pelvic examinations in asymptomatic, non-pregnant individuals. The proposed framework is one approach to using shared decision making during these encounters. This framework can also be used around whether to perform a pelvic examination under additional circumstances and additional exam components, including the rectal exam.

5. Ethicists commonly discuss 4 fundamental aspects of bioethics in health care- autonomy is only of these 4 (beneficence, non malfeasance, autonomy, justice). What evidence suggests autonomy is paramount?

RESPONSE: The primacy of autonomy has been removed in this revision.

Lines: 144-9: Finally, the pelvic examination encounter can be conducted in such a way to foster patients' bodily autonomy in healthcare provision, and in developing empowering and positive patient-provider relationships. Historically and in contemporary practice, a great power differential has existed within the patient-provider relationship. Integrating shared decision making into discussions of whether or not to conduct the pelvic examination empowers patients to express their preferences and opinions during clinical encounters.

6. please define: Step-wise consent, power change, trauma-informed care,and "debriefing" post-exam"

RESPONSE: This jargony language has been removed from this revision. The exception is with the reference to trauma-informed care which is more explicitly discussed in this revision.

Lines: 149-54: This can be especially important for patients with prior sexual or other trauma who may want to avoid an invasive examination. Patients with a history of sexual assault may be at risk of experiencing distress, pain, or re-traumatization during the examination. Shared decision making incorporates key principles of trauma-informed care that further empower patients and foster human agency and bodily autonomy in healthcare decisions, including trustworthiness, transparency, and collaboration.

7. what are the principle of mutuality and of voluntariness?

RESPONSE: This jargony language has been removed from this revision.

8. The Journal style doesn't not use the virgule (/) except in numeric expressions. Please edit here and in all instances.

RESPONSE: The revised manuscript now has removed the use of the virgule.

9. what about rectal examination? or parts of the exam

RESPONSE: The rectal examination and other parts of the examination are now referenced in this revision.

Lines 216-8: This framework can also be used around whether to perform a pelvic examination under additional circumstances and additional exam components, including the rectal exam.

10. pelvic self-awareness seems like a parallel to the terminology of "Breast self awareness" which never seemed to be well adopted. Is pelvic self-awareness a known terminology

RESPONSE: This term has been removed and replaced with a more common term, “pelvic health”.

Lines 204-7: *Educate regarding pelvic health and warning signs*. Regardless of whether a provider opts to follow the recommendations of the ACP and AAFP to not offer the pelvic examinations for asymptomatic patients or if a provider offers the examination and a patient declines the exam, educating patients on pelvic health and warning signs is critical.

11. aren't all dialogues bidirectional?

RESPONSE: The bidirectional nature of shared decision making is set in contrast to the unidirectional decision making in the paternalistic and consumerist decision making models.

Lines 101-9: Reflecting the changing nature of the patient-provider relationship, shared decision making developed as an alternative to prevailing models of decision making at that time – primarily the paternalistic and the consumerist models. Paternalism places knowledge and decision making in the hands of providers. Conversely, in consumerism, providers provide patients with large amounts of medical information and defer decision making entirely to patients. Both of these models are unidirectional, either the patient or the provider is left to make decisions alone. In contrast, shared decision making is bidirectional, recognizing two experts within the clinical encounter - the health care provider is the expert regarding medical information and the patient is the expert regarding their values, preferences, and lived experiences.

13. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

RESPONSE: We opt-in to this option.

14. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at http://links.lww.com/AOG/A515, and the gynecology data definitions are available

at http://links.lww.com/AOG/A935.

RESPONSE: Thank you for alerting us to these new definitions. We have reviewed them and believe that our terminology is consistent with these definitions.

15. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Current Commentary articles should not exceed 12 typed, double-spaced pages (3,000 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and appendixes).

RESPONSE: This revised manuscript follows the word and page limits as per the Green Journal requirements.

Word count: 2999

16. Specific rules govern the use of acknowledgments in the journal. Please edit your acknowledgments or provide more information in accordance with the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your signature on the journal's author agreement form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

Response: Acknowledgements in this manuscript revision meet the Green Journal requirements.

17. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Current Commentary articles, 250 words. Please provide a word count.

RESPONSE: The abstract in this revision reflects the information contained in the text and is less than 250 words in length.

18. Only standard abbreviations and acronyms are allowed. A selected list is available online at http://edmgr.ovid.com/ong/accounts/abbreviations.pdf. Abbreviations and acronyms cannot

be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

RESPONSE: Abbreviations have been revised accordingly.

19. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

RESPONSE: The revised manuscript now has removed the use of the virgule.

20. The American College of Obstetricians and Gynecologists' (College) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite College documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly. If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if a College document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All College documents (eg, Committee Opinions and Practice Bulletins) may be found via the Resources and Publications page at http://www.acog.org/Resources-And-Publications.

RESPONSE: The cited College documents are current as of this revision.

21. Figure 1 may be resubmitted as-is.

RESPONSE: Thank you. No changes have been made to Figure 1.

Randi Zung

From: Julie Chor [redacted]
Sent: Monday, January 7, 2019 10:55 AM
To: Randi Zung
Subject: Re: Your Revised Manuscript 18-2115R1
Attachments: 18-2115R1 ms (1-4-19v2)_1.4.18.docx; Green revision_1.4.18.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Categories: Blue Category

Randi-

Hello! Please see my attached responses to the edits/comments and my revised manuscript addressing these questions. My co-authors have indicated that they have completed their electronic Copyright Transfer Agreements. Please let me know if you have any questions.

Sincerely,
Julie Chor

On Mon, Jan 7, 2019 at 9:31 AM Julie Chor [redacted] wrote:

> Thank you!
>
> Sent from my iPhone
>
> On Jan 7, 2019, at 7:11 AM, Randi Zung <RZung@greenjournal.org> wrote:
>
> > Hello:
> >
> > The eCTA emails have been resent to your coauthors. The sender of message is EM@greenjournal.org.
> >
> > Thank you,
> >
> > Randi
> >
> > **From:** Julie Chor [redacted]
> > **Sent:** Sunday, January 6, 2019 12:13 PM
> > **To:** Randi Zung <RZung@greenjournal.org>
> > **Cc:** Stephanie Tillman <[redacted] Deb Stulberg [redacted]
> > **Subject:** Re: Your Revised Manuscript 18-2115R1

Hello!

Could you please resend the link to the Copyright Transfer Agreement to Debra Stulberg and Stephanie Tillman, copied on this email?

Many thanks,

Julie

On Fri, Jan 4, 2019 at 9:22 AM Randi Zung <RZung@greenjournal.org> wrote:

> Dear Dr. Chor:
>
> Your revised manuscript is being reviewed by the Editors. Before a final decision can be made, we need you to address the following queries. Please make the requested changes to the latest version of your manuscript that is attached to this email. **Please track your changes and leave the ones made by the Editorial Office.** Please also note your responses to the author queries in your email message back to me.
>
> 1. General: The Editor has made edits to the manuscript using track changes. Please review them to make sure they are correct.
>
> 2. Drs. Stulberg and Tillman will need to complete our electronic Copyright Transfer Agreement, which was sent to them from Editorial Manager. The form was sent to Dr. Stulberg at [redacted] and to Dr. Tillman at [redacted] Are these the correct email addresses?
>
> 3. Line 43: I am sure this is politically correct but aren't we talking about females specifically? No doubt males have what would be called a "pelvic examination" with respect to genitalia, rectal examination so it's not exactly correct to say "individuals" here. Would you consider "Females"? That is a sex not gender term and would apply to transgender males.
>
> 4. Line 65: Same issue as above.
>
> 5. Line 73: Would this be clearer to say, "the Society of Gynecologic Oncology recommends discussing the risks and benefits of a pelvic examination and that every patient presenting for an annual visit should be offered a pelvic exam". (seems like the order should be reversed).

6. Line 74: As this paper may be read years from now, could you give the year instead of saying “recently”?

To facilitate the review process, we would appreciate receiving a response by January 8.

Best,

Randi Zung

– –

Randi Zung (Ms.)

Editorial Administrator | *Obstetrics & Gynecology*

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From: [redacted]
To: Stephanie Casway
Subject: Re: O&G Figure Revision: 18-2115
Date: Thursday, January 3, 2019 12:29:05 PM

Hello and thank you for your email. Does this mean that the manuscript has been accepted?

I approve of the edited figure. Please see the figure legend below.

Figure 1. Pelvic examination shared decision making framework

Thank you,

Julie Chor

On Thu, Jan 3, 2019 at 8:37 AM Stephanie Casway <SCasway@greenjournal.org> wrote:

> Good Morning Dr. Chor,
>
> Your figure has been edited, and a PDF of the figure is attached for your review. Please review the figure CAREFULLY for any mistakes. In addition, please see our query below.
>
> AQ1: Please provide a legend for this figure.
>
> PLEASE NOTE: Any changes to the figures must be made now. Changes made at later stages are expensive and time-consuming and may result in the delay of your article's publication.
>
> To avoid a delay, I would be grateful to receive a reply no later than Monday, 1/7. Thank you for your help.
>
> Best wishes,
>
> Stephanie Casway, MA
> Production Editor
>
> *Obstetrics & Gynecology*

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