

OBSTETRICS & GYNECOLOGY



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- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

**The corresponding author has opted to make this information publicly available.*

Personal or nonessential information may be redacted at the editor's discretion.

Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office:

obgyn@greenjournal.org.

Date: Sep 30, 2019
To: "Gregory Matthew Gressel" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-1595

RE: Manuscript Number ONG-19-1595

Hysterectomy route and numbers reported by graduating residents in obstetrics and gynecology training programs

Dear Dr. Gressel:

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 Oct 21, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: The authors present a study describing Ob/Gyn resident self-reported numbers for hysterectomy and route of hysterectomy between 2002-2003 and 2017-2018 using the ACGME case-log database. The authors found an overall decrease in cases logged as surgeon, abdominal hysterectomies, vaginal hysterectomies and total hysterectomies over time, while the number of laparoscopic hysterectomies significantly increased.

1. Overall, the paper is easy to follow and concise. The study is similar to the study published by Washburn, et al evaluating trends in hysterectomy numbers and routes for residents graduating from 2002 to 2012.
2. The abstract, introduction and methods are concise and appropriate in length.
3. If the authors had a hypothesis a priori please state at the end of your introduction.

Results:

4. Line 94—Add p-value to the results since the authors state there was a significant decrease in median number of abdominal hysterectomies over time.

Discussion:

5. Lines 122-125: You state the significant decrease in ACGME-accredited residency programs and the increase in number of residents may be the cause of changing hysterectomy numbers. Do you have studies to support this statement? If not, this statement should be modified as it is conjecture.
6. Line 126-128: Please cite the studies being referred.
7. You allude to the utilization of procedures such as endometrial ablation, uterine artery embolization and myomectomy, as well as medications in lieu of hysterectomy to be a contribution to the decreasing hysterectomy numbers nationally. Did you consider looking at resident-reported numbers for these procedures throughout the same time-frame to assess if they have changed, as well? The addition of these numbers would make the manuscript more robust and novel, especially when comparing their study to that of Washburn, et al.
8. How do you reconcile the disconnect between your study's findings that resident-reported laparoscopic hysterectomy numbers have dramatically increased over the time period studied while the studies discussed in lines 159-167 show both trainees and educators do not feel residents are adequately prepared to perform these procedures? Should we still be looking at resident-reported numbers based on these findings?

9. Please state limitations and strengths of your study in the discussion.

Tables and Figures:

10. Clearly labeled and add to the manuscript.

Reviewer #2: Gressel et al present a retrospective observational study using ACGME ObGyn residency case log data to describe trends in hysterectomy numbers among US trainees. Overall the article is clear, concise and well-written and provides significant information to inform a discussion of the future of residency training for ObGyn. The authors allude to possible next steps based on this data but do not make strong recommendations.

Precis

Line 25 - Would recommend "fewer" instead of "less"

Materials and Methods

Line 70 Were all graduating residents included in analysis or were there any resident-level data that were excluded or missing?

Line 73 Please clarify what a "total" hysterectomy is - is this total abdominal, total vaginal, total laparoscopic? Or did the authors mean to indicate total laparoscopic and laparoscopic assisted vaginal hysterectomy numbers were not collected until 2008?

Line 72 Prior to 2008 did residents record any laparoscopic hysterectomies in another category or were these not reported?

Discussion

113-114 The authors state that the total number of hysterectomies has decreased from 2002 to present, but data regarding total hysterectomy numbers from 2002 to 2008 is absent from Table 1 and is not mentioned in results.

152 Although the trend is significant, the absolute decrease in number of total hysterectomies performed is small relative to the total number performed (decrease of 7 total from 2008 to present out of 105 performed in 2008). The authors discuss diversification of approaches later which may in fact impact resident preparedness more than the total numbers. Additionally, the evolving technology involved in laparoscopy provides additional challenges to trainees that may not be analogous the learning curve involved in abdominal hysterectomy.

159-163 Data regarding the number of ObGyn surgical fellowships during this time period would be interesting to help interpret the effect this might have on resident preparedness. Additionally, the rise of MIGS fellowship training programs may be influenced by trends noted here.

Are there interesting trends that have been reported in other surgical specialties that have affected training or evaluation of competency?

Please comment on the significance of changes in the "teaching assistant" numbers.

Reviewer #3: This is a solid descriptive study outlining hysterectomy rates and trends among OB/GYN residents nationally. My main issue is whether the conclusion is correct. Do you think a 6% decrease 112 to 105 total hysterectomies to be meaningful? It is not enough to say that it is statistically significant, we need more interpretation as to its actual significance. What are the recommended minimum numbers? I thought the ACGME had those. I would change the conclusions to say the number has slightly decreased. Of more concern to me would be the dilution e.g. only knowing how to do one type of hysterectomy well (nowadays laparoscopic) and not knowing the other kinds which you mention in the discussion. That is very common among graduates.

1. Methods: Please clarify when you are talking about a graduating resident reporting hysterectomies, does the number reflect the total in residency or just the total for that year?

Reviewer #4: In this manuscript, the authors compared the number and types of hysterectomies performed by OBGYN residents between 2002-2003 versus those performed in 2017-2018, by using ACGME case-log database. They found that

the number of total hysterectomies performed by OBGYN residents in 2017-2018 decreased by 6.3% compared to 2002-2003. During the same period, the number of abdominal and vaginal hysterectomies decreased by 56.5% and 35.5% respectively while the number of laparoscopic hysterectomies increased by 115% from 2008-2009 to 2017-2018. The results of this study confirm what we have observed in our own experience and also confirm what we have long suspected that these trends already have had a significant adverse impact on the surgical training of our residents.

I have the following comments, concerns and questions.

1. Despite the progressively decreasing number of hysterectomies, the number of residents in OBGYN residency programs has progressively increased which further decreases the number of hysterectomies that our residents perform during their training.
2. Should we not increase the number of accredited training programs and decrease the number of residents per program?
3. This deficiency in our residency training is further documented by the reports that a large number of our graduating residents do not feel adequately prepared to perform hysterectomies of any type. And-
4. Many fellowship directors also feel that the majority of first year fellows are not able to independently perform either abdominal (56%) or vaginal (80%) hysterectomies.
5. This should be an urgent call for action to address this very important issue and I strongly recommend that the authors emphasize in their discussion the urgency of addressing these concerns.
6. Should we encourage our graduating residents who want to practice general OBGYN to limit their practice to normal obstetrics, minor gynecologic surgery and office gynecology while encouraging the gynecologic surgeons to pursue surgical fellowship training?
7. This study is very important and highlights the serious concerns in our residency training program that need to be addressed.
8. We are obviously not fulfilling the ACGME mandate that OBGYN "residents must develop and ultimately demonstrate proficiency in obstetric and gynecologic procedures essential for specialty board certification".
9. Either we change the ACGME mandate or change our training program.

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

lines 102-105, Table 2: Need to be more clear. Does the database have individual , ie, resident-level information regarding number and types of hysterectomies performed, or is the database a summary, giving program level information as to median, IQR etc? Do the decreases over time relate to changes in the median or mean values of the programs, if there is no individual level data? If means are given, is SD also given by program? If there is no individual level data, then care must be taken in estimation of CIs, since they cannot be based on the total number of residents per year, but rather on the number of residency programs. If a grand total of all programs has been used to estimate the relationship of year vs number of total hysterectomies, abd, lap and vag subsets, then the sample size is the years being compared for each procedure. Need to specify all this in the Methods, beginning with describing the format of the available data.

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.

- We no longer require that authors adhere to the Green Journal format with the first submission of their papers. However, any revisions must do so. I strongly encourage you to read the instructions for authors (the general bits as well as those specific to the feature-type you are submitting). The instructions provide guidance regarding formatting, word and reference limits, authorship issues, and other things. Adherence to these requirements with your revision will avoid delays during the revision process, as well as avoid re-revisions on your part in order to comply with the formatting. For example, please note the organization of original research papers and the different sections.

- You list here 4 different variables: Cases logged as surgeon, abd. hyst, vag hyst, lap hyst but provide only 3 percentages. Please edit for clarity.

- Reviewers wonder if # of residency programs changed over time. Can you make a comment about this here?

- While P values are a central part of inference testing in statistics, when cited alone, often the strength of the conclusion can be misunderstood. Whenever possible, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone. This is true for the abstract as well as the manuscript. It is insufficient to tell us the % change and state that they had decreased without providing the statistical support for this statement.

- Same issue as preceding comment

- do we know how accurate they are?

- please provide a reference for this statement.

- would you consider making this clearer (in my opinion--ok if you disagree) that this was for people who completed PGY 4 year from 2003 to 2018?

- Please clarify that what you looked at were PGY 4 logs for those finishing in 2002-20023 and 2017-2018. For those who are not familiar with the case logs, please indicate that the numbers reflect cumulative experience, not just those performed in the PGY 4 year.

- define 'total'

- why were these data missing?

- recall that many readers are not educators and will have no clue what the difference between surgeon and teaching assistant is. Please clarify.

- please provide statistical assessment

- Rather, does it suggest that since these results parallel the national hysterectomy data, that the indications for and route of hysterectomy has changed and that training numbers reflect this.

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. 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:

A. OPT-IN: Yes, please publish my point-by-point response letter.

B. OPT-OUT: No, please do not publish my point-by-point response letter.

3. As of December 17, 2018, Obstetrics & Gynecology has implemented an "electronic Copyright Transfer Agreement" (eCTA) and will no longer be collecting author agreement forms. When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

4. In order for a database study to be considered for publication in Obstetrics & Gynecology, the database used must be shown to be reliable and validated. In your response, please tell us who entered the data and how the accuracy of the database was validated. This same information should be included in the Materials and Methods section of the manuscript.

5. All studies should follow the principles set forth in the Helsinki Declaration of 1975, as revised in 2013, and manuscripts should be approved by the necessary authority before submission. Applicable original research studies should be reviewed

by an institutional review board (IRB) or ethics committee. This review should be documented in your cover letter as well in the Materials and Methods section, with an explanation if the study was considered exempt. If your research is based on a publicly available data set approved by your IRB for exemption, please provide documentation of this in your cover letter by submitting the URL of the IRB website outlining the exempt data sets or a letter from a representative of the IRB. In addition, insert a sentence in the Materials and Methods section stating that the study was approved or exempt from approval. In all cases, the complete name of the IRB should be provided in the manuscript.

6. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at <http://ong.editorialmanager.com>. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

7. 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 has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at <https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize>. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

8. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

9. Specific rules govern the use of acknowledgments in the journal. Please note 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 response in the journal's electronic author 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).

10. Précis: Please edit the existing sentence to say "fewer," instead of "significantly less."

11. 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: Original Research articles, 300 words. Please provide a word count.

12. Abstract-Results: Please add a n's to this section for abdominal hysterectomies, vaginal hysterectomies and total number of hysterectomies.

13. 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.

14. 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.

15. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size,

such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%).

16. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

17. Figure 1 and 2: Are these figures available in color?

18. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at <http://links.lww.com/LWW-ES/A48>. The cost for publishing an article as open access can be found at <http://edmgr.ovid.com/acd/accounts/ifaauth.htm>.

Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

19. If you choose to revise your manuscript, please submit your revision through Editorial Manager at <http://ong.editorialmanager.com>. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

- * A confirmation that you have read the Instructions for Authors (<http://edmgr.ovid.com/ong/accounts/authors.pdf>), and
- * A point-by-point response to each of the received comments in this letter.

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

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 Oct 21, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

2018 IMPACT FACTOR: 4.965
2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: <https://www.editorialmanager.com/ong/login.asp?a=r>). Please contact the publication office if you have any questions.

Nancy C. Chescheir, MD
Editor-in-Chief
409 12th Street, SW
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obgyn@greenjournal.org

Dear. Dr. Chescheir, the Editorial Board, and Expert Referees,

Thank you for your careful and thoughtful review of our manuscript "Hysterectomy route and numbers reported by graduating residents in obstetrics and gynecology training programs." We appreciate all of the comments made by the individual reviewers. Please find our responses to each of these comments below in red.

Reviewer #1: The authors present a study describing Ob/Gyn resident self-reported numbers for hysterectomy and route of hysterectomy between 2002-2003 and 2017-2018 using the ACGME case-log database. The authors found an overall decrease in cases logged as surgeon, abdominal hysterectomies, vaginal hysterectomies and total hysterectomies over time, while the number of laparoscopic hysterectomies significantly increased.

Thank you for your careful and thorough review of our manuscript.

1. Overall, the paper is easy to follow and concise. The study is similar to the study published by Washburn, et al evaluating trends in hysterectomy numbers and routes for residents graduating from 2002 to 2012.

Thank you.

2. The abstract, introduction and methods are concise and appropriate in length.

Thank you.

3. If the authors had a hypothesis a priori please state at the end of your introduction.

Thank you for pointing this out. Our *a priori* hypothesis is that the number of hysterectomy procedures reported by graduating residents has decreased significantly over time. We have included this in our revised manuscript (lines 75-76).

Results:

4. Line 94—Add p-value to the results since the authors state there was a significant decrease in median number of abdominal hysterectomies over time.

Thank you for pointing this out. We have included p-values for change in these procedures overtime (lines 114-132).

Discussion:



5. Lines 122-125: You state the significant decrease in ACGME-accredited residency programs and the increase in number of residents may be the cause of changing hysterectomy numbers. Do you have studies to support this statement? If not, this statement should be modified as it is conjecture.

There are no comprehensive studies examining the association of resident complement numbers and saturation of availability of hysterectomy procedures. We had meant this statement to be hypothesis generating but based on your comment, have modified the statement to clarify that concrete data supporting our conjecture are lacking (lines 155-159).

6. Line 126-128: Please cite the studies being referred.

See comment above.

7. You allude to the utilization of procedures such as endometrial ablation, uterine artery embolization and myomectomy, as well as medications in lieu of hysterectomy to be a contribution to the decreasing hysterectomy numbers nationally. Did you consider looking at resident-reported numbers for these procedures throughout the same time-frame to assess if they have changed, as well? The addition of these numbers would make the manuscript more robust and novel, especially when comparing their study to that of Washburn, et al.

This is an excellent suggestion. While we would love to include these numbers in our study, these procedures are not tracked by the RRC and are not tracked in the national ACGME data on which this review is done. We are unable to analyze them for inclusion in our paper.

8. How do you reconcile the disconnect between your study's findings that resident-reported laparoscopic hysterectomy numbers have dramatically increased over the time period studied while the studies discussed in lines 159-167 show both trainees and educators do not feel residents are adequately prepared to perform these procedures? Should we still be looking at resident-reported numbers based on these findings?

We feel that there is a difference between number of procedures performed and self-reported confidence or any measure of competency to perform those procedures. While case log data is an imperfect metric for any measure of resident competency and are utilized by the ACGME for program accreditation, we feel that these case logs represent the most complete and accurate measure of available resident operative experience and trends over time. We have clarified this in lines 65-70.

9. Please state limitations and strengths of your study in the discussion.

We appreciate you pointing out this omission. We have included a paragraph detailing strengths and limitations (lines 162-172).

Tables and Figures:

10. Clearly labeled and add to the manuscript.



Thank you.

Reviewer #2: Gressel et al present a retrospective observational study using ACGME ObGyn residency case log data to describe trends in hysterectomy numbers among US trainees. Overall the article is clear, concise and well-written and provides significant information to inform a discussion of the future of residency training for ObGyn. The authors allude to possible next steps based on this data but do not make strong recommendations.

We appreciate you taking the time to review this manuscript. Please find responses to your comments below.

Precis

Line 25 - Would recommend "fewer" instead of "less"

Changed

Materials and Methods

Line 70 Were all graduating residents included in analysis or were there any resident-level data that were excluded or missing?

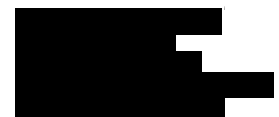
All graduating residents were included in the data. The ACGME Obstetrics and Gynecology Case Log Data includes all data submitted by US residents in training programs to the ACGME on a yearly basis. ACGME reports that to the best of their knowledge the cases reported by resident includes all their cases they performed. There could be missing data in the form of cases that were performed by residents who did not *complete* an OB-GYN residency (because they transferred or were dismissed) and, hence, are not reflected in the graduate data. We have only the cases that the residents graduating logged during their residency and can speak to no other data. All data included in the database was used for analysis and we did not exclude any data for any reason.

Line 73 Please clarify what a "total" hysterectomy is - is this total abdominal, total vaginal, total laparoscopic? Or did the authors mean to indicate total laparoscopic and laparoscopic assisted vaginal hysterectomy numbers were not collected until 2008?

In 2008, the ACGME began calculating and reporting the "total" number of hysterectomy procedures graduating residents performed (by adding all types of hysterectomies). It is not meant to refer to whether or not a cervix was removed. We have clarified this in lines 87-94.

Line 72 Prior to 2008 did residents record any laparoscopic hysterectomies in another category or were these not reported?

Prior to 2008, there was a category entitled "operative laparoscopy" which presumably included laparoscopic hysterectomy procedures. However, because there is no way to parse out whether or not these were simple adnexal surgeries or diagnostic laparoscopies rather than



hysterectomies, only the data from 2008 onwards was analyzed. We have clarified this in lines 90-94.

Discussion

113-114 The authors state that the total number of hysterectomies has decreased from 2002 to present, but data regarding total hysterectomy numbers from 2002 to 2008 is absent from Table 1 and is not mentioned in results.

Thank you for pointing this out this typographical error- you are correct that data regarding "Total number of hysterectomies" is missing from 2002-2008. We had meant to state "...decreased significantly from 2008 to the present", and have corrected this in line 134-135.

152 Although the trend is significant, the absolute decrease in number of total hysterectomies performed is small relative to the total number performed (decrease of 7 total from 2008 to present out of 105 performed in 2008). The authors discuss diversification of approaches later which may in fact impact resident preparedness more than the total numbers. Additionally, the evolving technology involved in laparoscopy provides additional challenges to trainees that may not be analogous the learning curve involved in abdominal hysterectomy.

We agree with this. We have added to our discussion that while this trend is significant for total number of hysterectomies, the absolute reduction is relatively small (lines 143-148). We also agree with your comments about diversification of procedures and have included it as a caveat in lines 200-206.

159-163 Data regarding the number of ObGyn surgical fellowships during this time period would be interesting to help interpret the effect this might have on resident preparedness. Additionally, the rise of MIGS fellowship training programs may be influenced by trends noted here.

AAGL shared that their fellowships have increased from 43 fellowship programs in 2011 to 50 in 2019. And ACGME shared that FPMRS fellowship programs have increased from 44 in 2012 to 52 in 2019 and the number of graduating fellows has increased from 75 in 2012 to an anticipated 149 in 2020.

Are there interesting trends that have been reported in other surgical specialties that have affected training or evaluation of competency?

There are examples in other surgical fields. For example, open treatment of cerebral aneurysms is fading in the face of endovascular treatment and open cholecystectomy is much less common in light of advanced laparoscopic procedures. Given that we have no expertise or knowledge base in these areas and because we feel that they will not be broadly interpretable to the OBGYN community of readers, we have limited our discussion to hysterectomies.

Please comment on the significance of changes in the "teaching assistant" numbers.



The category of “teaching assistant” was added in 2009 in order to allow residents to take advantage of cases in which a senior resident acts as a surgical teacher to junior residents. Because this data was not previously collected and is now included, this indicates an overall decrease in the absolute number of hysterectomies being performed. Because a single hysterectomy can be logged by 2 residents, it is likely that we are over-estimating the total number of hysterectomies being performed. We have added this information in lines 148-155.

Reviewer #3: This is a solid descriptive study outlining hysterectomy rates and trends among OB/GYN residents nationally. My main issue is whether the conclusion is correct. Do you think a 6% decrease 112 to 105 total hysterectomies to be meaningful? It is not enough to say that it is statistically significant, we need more interpretation as to its actual significance. What are the recommended minimum numbers? I thought the ACGME had those. I would change the conclusions to say the number has slightly decreased. Of more concern to me would be the dilution e.g. only knowing how to do one type of hysterectomy well (nowadays laparoscopic) and not knowing the other kinds which you mention in the discussion. That is very common among graduates.

Thank you for reviewing our manuscript. We agree that the absolute reduction in total number of hysterectomies seems unimpressive even if statistically significant. However, it is the diversification of hysterectomy procedures which is most interesting. Our goal in writing this manuscript is to raise questions and generate conversations about the importance of these trends rather than make any definitive conclusions, especially in light of the recently increased minimum by our OBGYN RRC. We have included discussion about the relatively small decrease in absolute number of hysterectomies in lines 143-148 and discussed the actual minimum numbers of cases required by the ACGME (The minimums were recently changed from 25 TAH 35 LSC and 15 VH for a total minimum hysterectomies of 65 to 15 TAH, 15 LSC and 15 vaginal by with a minimum of 70 “minimally invasive” (LSC + VH) and 85 overall).

1. Methods: Please clarify when you are talking about a graduating resident reporting hysterectomies, does the number reflect the total in residency or just the total for that year?

We have clarified this in the manuscript (lines 82-87): The data reported is individual-level data including means, medians, standard deviations and quantiles of numbers of procedures performed by a single graduating resident during their 4 year-long residency. The interpretation of a median for example, is the median number of procedures performed by a graduating resident.

Reviewer #4: In this manuscript, the authors compared the number and types of hysterectomies performed by OBGYN residents between 2002-2003 versus those performed in 2017-2018, by using ACGME case-log database. They found that the number of total hysterectomies performed by OBGYN residents in 2017-2018 decreased by 6.3% compared to 2002-2003. During the same period, the number of abdominal and vaginal hysterectomies decreased by 56.5% and 35.5% respectively while the number of laparoscopic hysterectomies increased by 115% from 2008-2009 to 2017-2018. The results of this study confirm what we have observed in our own experience and also confirm what we have long suspected that these trends already have had a significant adverse impact on the surgical training of our residents.



Thank you for all of your comments and for reviewing our manuscript critically.

I have the following comments, concerns and questions.

1. Despite the progressively decreasing number of hysterectomies, the number of residents in OBGYN residency programs has progressively increased which further decreases the number of hysterectomies that our residents perform during their training.

We agree with you. We have mentioned this concern in our manuscript discussion.

2. Should we not increase the number of accredited training programs and decrease the number of residents per program?

This is certainly a potential option which we have mentioned in lines 286-288. We would like this paper to raise questions within the OBGYN educational community regarding the appropriate way to maximize surgical exposure for US OBGYN residents.

3. This deficiency in our residency training is further documented by the reports that a large number of our graduating residents do not feel adequately prepared to perform hysterectomies of any type.

We agree, this is also a huge concern- we have referenced these reports in our discussion: Lines 206-218.

4. Many fellowship directors also feel that the majority of first year fellows are not able to independently perform either abdominal (56%) or vaginal (80%) hysterectomies.

Agreed.

5. This should be an urgent call for action to address this very important issue and I strongly recommend that the authors emphasize in their discussion the urgency of addressing these concerns.

Thank you. We have tried our best to draw attention to the importance of this topic and to encourage discussion regarding optimal approaches to improve US OBGYN residency training.

6. Should we encourage our graduating residents who want to practice general OBGYN to limit their practice to normal obstetrics, minor gynecologic surgery and office gynecology while encouraging the gynecologic surgeons to pursue surgical fellowship training?

We have mentioned the idea of tracking throughout residency training as well as limiting exposure to certain procedures to those who will practice them in their future career (lines 222-234).



7. This study is very important and highlights the serious concerns in our residency training program that need to be addressed.

Thank you we agree.

8. We are obviously not fulfilling the ACGME mandate that OBGYN "residents must develop and ultimately demonstrate proficiency in obstetric and gynecologic procedures essential for specialty board certification".

Thank you we agree with your concern.

9. Either we change the ACGME mandate or change our training program.

Appreciate all of your comments. We hope that this paper will generate some important discussions about the future of training OBGYN residents.

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

lines 102-105, Table 2: Need to be more clear. Does the database have individual, ie, resident-level information regarding number and types of hysterectomies performed, or is the database a summary, giving program level information as to median, IQR etc? Do the decreases over time relate to changes in the median or mean values of the programs, if there is no individual level data? If means are given, is SD also given by program? If there is no individual level data, then care must be taken in estimation of CIs, since they cannot be based on the total number of residents per year, but rather on the number of residency programs. If a grand total of all programs has been used to estimate the relationship of year vs number of total hysterectomies, abd, lap and vag subsets, then the sample size is the years being compared for each procedure. Need to specify all this in the Methods, beginning with describing the format of the available data.

We have clarified the methods section to indicate that the available data is summarial, resident-level data including means, medians, standard deviations and IQRs. The reported values are related to national resident averages (e.g. the median values refer to median number of procedures performed per resident in the nation). The decreases in time relate to changes in median values (lines 80-95).

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.

- We no longer require that authors adhere to the Green Journal format with the first submission of their papers. However, any revisions must do so. I strongly encourage you to read the instructions for authors (the general bits as well as those specific to the feature-type you are submitting). The instructions provide guidance regarding formatting, word and reference limits, authorship issues, and other things. Adherence to these requirements with your revision will avoid delays during the revision process, as well as avoid re-revisions on your part in order to comply with the formatting. For example, please note the organization of original research papers and the different sections.

Dr. Chescheir, thank you for reviewing our paper. We have read the instructions for authors and believe we have adhered to your formatting guidelines.

- You list here 4 different variables: Cases logged as surgeon, abd. hyst, vag hyst, lap hyst but provide only 3 percentages. Please edit for clarity.

We can see how this is confusing. We had meant that for cases logged by residents in the role of "surgeon," we examined numbers of abdominal, vaginal and total number of hysterectomies. We have clarified this in lines 33-36.

- Reviewers wonder if # of residency programs changed over time. Can you make a comment about this here?

Thank you, we included this in lines 38-41.

- While P values are a central part of inference testing in statistics, when cited alone, often the strength of the conclusion can be misunderstood. Whenever possible, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone. This is true for the abstract as well as the manuscript. It is insufficient to tell us the % change and state that they had decreased without providing the statistical support for this statement.

We have included statistical support here to include p values in addition to the % change in number of hysterectomies overtime. These particular percentages refer to the absolute percent change in the median number of individual procedures throughout the time period. While we have included effect sizes including beta-coefficients in our linear regression results, we are unfortunately unable to produce odds ratios or relative risk ratios with the available data.

- Same issue as preceding comment



Thank you, we have included statistical support for this.

- do we know how accurate they are?

We are not able to find any literature examining the accuracy of ACGME case logs. We have mentioned in the discussion of our study limitations that data input error by residents may result in over or under-estimation of hysterectomy numbers. Because this data is so essential for program accreditation, we can only assume that program directors are closely monitoring these logging data in order to make sure that program numbers are accurately represented.

- please provide a reference for this statement.

We have added references for this statement.

- would you consider making this clearer (in my opinion--ok if you disagree) that this was for people who completed PGY 4 year from 2003 to 2018?

Absolutely- we changed the years to remove ranges so that this is easier for the reader to interpret.

- Please clarify that what you looked at were PGY 4 logs for those finishing in 2002-20023 and 2017-2018. For those who are not familiar with the case logs, please indicate that the numbers reflect cumulative experience, not just those performed in the PGY 4 year.

We have clarified this lines 80-87.

- define 'total'

We agree that this was confusing how we worded this. We had meant total number of hysterectomies, rather than total hysterectomies. We have reworded this.

- why were these data missing?

The data for each hysterectomy approach is available for 2012-2013 but not for total number of hysterectomies. The ACGME is not aware why they did not publish the the total hysterectomy number from 2012-2013.

- recall that many readers are not educators and will have no clue what the difference between surgeon and teaching assistant is. Please clarify.

We have clarified this in lines 94-98 and included significance of this designation in our discussion as well (lines 148-155).

- please provide statistical assessment



We have included statistical assessments for each figure as requested (lines 108-126).

- Rather, does it suggest that since these results parallel the national hysterectomy data, that the indications for and route of hysterectomy has changed and that training numbers reflect this.

We agree wholeheartedly, we have included this alternative explanation in our discussion (lines 159-161).

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. 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:

- A. OPT-IN: Yes, please publish my point-by-point response letter.
- B. OPT-OUT: No, please do not publish my point-by-point response letter.

A. OPT-IN: Yes, please publish my point-by-point response letter.

3. As of December 17, 2018, Obstetrics & Gynecology has implemented an "electronic Copyright Transfer Agreement" (eCTA) and will no longer be collecting author agreement forms. When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

The authors of our study have no relevant conflicts of interest to report and have included a conflict of interest statement in the manuscript.

4. In order for a database study to be considered for publication in Obstetrics & Gynecology, the database used must be shown to be reliable and validated. In your response, please tell us who entered the data and how the accuracy of the database was validated. This same information should be included in the Materials and Methods section of the manuscript.

We have spoken with ACGME leadership regarding the accuracy of their publicly available resident case-log database. The data includes all data entered by graduating residents of all accredited US OBGYN training programs and has been verified by program directors for each of those institutions. The ACGME considers this data valid enough to be the basis for accreditation decisions. We have included this information in lines 63-66.

5. All studies should follow the principles set forth in the Helsinki Declaration of 1975, as revised in 2013, and manuscripts should be approved by the necessary authority before submission.



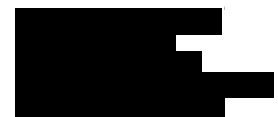
Applicable original research studies should be reviewed by an institutional review board (IRB) or ethics committee. This review should be documented in your cover letter as well in the Materials and Methods section, with an explanation if the study was considered exempt. If your research is based on a publicly available data set approved by your IRB for exemption, please provide documentation of this in your cover letter by submitting the URL of the IRB website outlining the exempt data sets or a letter from a representative of the IRB. In addition, insert a sentence in the Materials and Methods section stating that the study was approved or exempt from approval. In all cases, the complete name of the IRB should be provided in the manuscript.

This study was reviewed by the Albert Einstein College of Medicine Institutional Review Board and was determined to be exempt from approval as we are using a publicly available database. We have included this in our materials and methods section (lines 79-80) and have included an IRB exemption letter with our revised submission.

6. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at <https://nam04.safelinks.protection.outlook.com/?url=http%3A%2F%2Fong.editorialmanager.com&data=02%7C01%7C%7C1fb21ddf045c467347fc08d745b51d73%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C1%7C637054516499793707&data=nsj50trIG4kCd%2BGIENDMrMqXZ%2FuF8gRZhqGdPeuLz8%3D&reserved=0>. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

We have followed the STROBE guidelines for observational cohort studies and have included a copy of this checklist with our resubmission.

7. 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 has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at <https://nam04.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2FAbout-ACOG%2FACOG-Departments%2FPatient-Safety-and-Quality-Improvement%2FreVITALize&data=02%7C01%7C%7C1fb21ddf045c467347fc08d745b51d>



[73%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C1%7C637054516499793707&sdata=XLEaYXI2mjMy11MteBocqiCHU8Xv0A8yHp85jxl6PV0%3D&reserved=0](https://doi.org/10.1093/ajph/111.10.1649). If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

We have reviewed these definitions and we believe our manuscript is in compliance with the reVITALize terminology.

8. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

Our manuscript falls within these length restrictions.

9. Specific rules govern the use of acknowledgments in the journal. Please note 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 response in the journal's electronic author 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).

This work was not previously presented and all due credit has been attributed to the study authors.

10. Précis: Please edit the existing sentence to say "fewer," instead of "significantly less."

Thank you we have changed this.

11. 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.



We have reviewed the abstract and cross referenced carefully with the body text.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count.

Our abstract is 268 words.

12. Abstract-Results: Please add a n's to this section for abdominal hysterectomies, vaginal hysterectomies and total number of hysterectomies.

We have included this at your request: lines 41-49.

13. Only standard abbreviations and acronyms are allowed. A selected list is available online at <https://nam04.safelinks.protection.outlook.com/?url=http%3A%2F%2Fedmgr.ovid.com%2Fong%2Faccounts%2Fabbreviations.pdf&data=02%7C01%7C%7C1fb21ddf045c467347fc08d745b51d73%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C1%7C637054516499793707&data=%2B3b6DcrKSOPH%2FGfR3HQeQpP9fUm9Nqs%2FpzOlUf71S0%3D&reserved=0>. 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.

Thank you, our only frequently used abbreviation is ACGME which is not present in the title or in the precis and has been spelled out in the body of the paper.

14. 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.

We have not used the virgule symbol.

15. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

We have included effect sizes whenever possible and appropriate.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.



This is not applicable to our paper.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%).

We have adhered to these guidelines.

16. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: https://nam04.safelinks.protection.outlook.com/?url=http%3A%2F%2Fedmgr.ovid.com%2Fong%2Faccounts%2Ftable_checklist.pdf&data=02%7C01%7C%7C1fb21ddf045c467347fc08d745b51d73%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C1%7C637054516499793707&data=W1wmw2%2FdBhF5No8oX3omJD%2F8gC%2FL4vp%2BO1qLHpWLYYU%3D&data=reserved=0.

Our tables conform to the journal's style.

17. Figure 1 and 2: Are these figures available in color?

Absolutely, we have included color figures with our re-submission.

18. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at <https://nam04.safelinks.protection.outlook.com/?url=http%3A%2F%2Flinks.lww.com%2FLWW-ES%2FA48&data=02%7C01%7C%7C1fb21ddf045c467347fc08d745b51d73%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C1%7C637054516499793707&data=25KZclCwNzRxX3YJahkw37lqeINV9nU7Dp4DluRZapE%3D&data=reserved=0>. The cost for publishing an article as open access can be found at <https://nam04.safelinks.protection.outlook.com/?url=http%3A%2F%2Fedmgr.ovid.com%2Faccounts%2Fifauth.htm&data=02%7C01%7C%7C1fb21ddf045c467347fc08d745b51d73%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C1%7C637054516499793707&data=9LpXOzEhiF8mb%2BB3stxgsA2ZEcvHMXlGPgMOlu%2BZ5U%3D&data=reserved=0>.

Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

We would prefer traditional publication and will respond to the email appropriately.

19. If you choose to revise your manuscript, please submit your revision through Editorial Manager at <https://nam04.safelinks.protection.outlook.com/?url=http%3A%2F%2Fong.editorialmanager.com&data=02%7C01%7C%7C1fb21ddf045c467347fc08d745b51d73%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C1%7C637054516499793707&data=9LpXOzEhiF8mb%2BB3stxgsA2ZEcvHMXlGPgMOlu%2BZ5U%3D&data=reserved=0>



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and

* A point-by-point response to each of the received comments in this letter.

Included

