OBSTETRICS & GYNECOLOGY

NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- 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: Dec 05, 2019
To: "Ella Anne Damiano" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-1998

RE: Manuscript Number ONG-19-1998

Singleton Term Vertex Cesarean Delivery by Midwifery Service Compared with Physician-led Obstetrician Service

Dear Dr. Damiano:

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 14 days from the date of this letter. If we have not heard from you by Dec 19, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: Damiano and colleagues present a retrospective cohort study evaluating difference in cesarean delivery rate between a midwifery labor service and an obstetrician-led labor service. I have the following questions/comments for the authors:

1- Please amend the short title as this makes it seem that the midwives are performing cesareans.

2- The abstract is clear and well-written.

3- Line 63 - The text references "studies" plural but here is only one reference. Please correct.

4- The methodology is well described.

5- Line 83 - Are there any patient factors that would make them ineligible for midwifery care at your institution? Many institutions with different delivery services have criteria that exclude patients from lower risk care.

6- Line 201 - Consider adding malpractice concerns to your possible influences.

7- Line 205 - Describing what you will be tracking in the future seems odd here and does not pertain to the data you are able to present. If you want to show understanding that there is an alternate metric and that that wasn't what you were able to collect, I would rephrase.

8- Tables - Consider bold type for statistically significant p values for ease of reading. The tables are well designed.

Reviewer #2: Dr. Damiano and colleagues performed a retrospective cohort study to determine whether the rate of cesarean delivery differed by Midwifery or Physician led service. Very nice and timely study to highlight how differences in labor management training can be a modifiable factor to reduce the cesarean delivery rate. I recommend consideration to rewording the title to "Singleton Term Vertex Cesarean Delivery in a Midwifery Service Compared with Physician-led Obstetrician Service". Additionally, assessing and reporting differences in neonatal morbidity such as need for respiratory support, NICU admission, meconium aspiration etc. would further strengthen this study.

Reviewer #3: If I am reading this correctly, you picked the groups based upon the admitting service. Is it not likely that patients were transferred from the midwifery service to the physician service prior to admission? I can imagine diagnoses like gestational hypertension, previa, oligohydramnios and IUGR as possible indications for transfer to physicians (though not necessarily MFM which would have excluded them from analysis?) This certianly would bias the results. You do a nice job of discussing reasons why the patients may be different beyond BMI and medical conditions like SES, labor support, birthing preferences but you don't really address patient culture. It is well described in the literature that patients who choose midwifery care, especially community out of hospital birth patients, have a very different culture more focused upon the birth experience rather than upon statistics and medical risk. Can you address this further in your manuscript? You don't have a very robust measure for outcome beyond Apgar. Could you at least look at NICU admissions or try to develop a composite of Apgar, NICU admission, cord pH, neonatal seizures?

STATISTICAL EDITOR COMMENTS:

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

Reviewer #4: lines 39-41: These are not odds, but rather frequencies or proportions. The primary outcomes should be stated as n(%) for each cohort, then as aORs with CIs. The primary outcome should be stated first, then all the secondary ones.

Table 1: Should include the GA (weeks) for each cohort and include in stats testing at baseline. Should include finer grain detail, such as n(%) of births at each week of GA. Need units for maternal age. Should expand the parity to include information on women with multiple prior births in each cohort, rather than nulliparity only.

Table 2: What were the reasons for "elective" cesarean? Was that based on maternal decision or preference?

Table 3: Should clearly separate the primary from the secondary outcomes. Should indicate the statistically significant ORs and aORs by emboldening them (thus eliminating ambiguity when a CI boundary = 1.00). Should indicate in a footnote which variables were retained in the final model. Should indicate whether the referent for age is per 1 year, the referent for BMI is per 1 kg/m^2. Some of the variables (eg, maternal DM or advanced maternal age etc) per Table 2 were relatively infrequent and thus there is likely not enough information to precisely adjust for multiple covariates.

General: Given that the groups were not randomly assigned and that there were baseline differences in demographic variables, and factors cited in Table 2, it would strengthen the Authors' conclusion to perform propensity matching of the two cohorts to corroborate the difference in the primary outcome.

EDITOR'S COMMENTS

Line 29: 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.

Line 31: In methods section, please describe how women are assigned to the MD vs CNM led service. Delete “of 1787” here as it is the results section.

Line 36: Do you between these dates or from these dates? How many total deliveries are there at the hospitals and on the 2 services?

It would be best to always present your data in the same order: midwfe vs physician OR physician vs Midwife. The consistency will require a change in use of increased and decreased, but will make it easier for the reader to keep track of what comparisons are being made.

P Values vs Effect Size and Confidence Intervals: 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.

Please provide absolute values for variables, in addition to assessment of statistical significance.

We ask that you provide crude OR's followed by adjusted OR's for all variables.

Line 42: Virginia Apgar is the source of the word. Its not an acronym so should not be in all caps.

Line 45: on line 44 you say you adjusted for "all maternal and delivery characteristics". What do you mean here about "other factors"?

Line 59; WHAT is "routine data"?

Line 65: should be NTSV or TSV?

Line 91: what is providing prenatal care in Pods? Is it relevant where they provide care?

Line 94: are there criteria for risking in and out of midwifery care? What happened if a patient was transferred from one service to the other part way through the pregnancy? What service was she "assigned" to at delivery? What service is "assigned" if a patient is delivered, for instance, by a midwife who was laboring with the MDs who were all tied up in deliveries and couldn't attend the birth (or vice versa)?

Line 111: birth weight is problematic here as it is not known until after the birth so its potential influence on intrapartum decision making is nil. Do you have EFW?

Line116: We use reVITALize terminology now. For instance, this is now prelabor rupture of the membranes. Similarly on line 120, its gestational hypertension, not PIH

Line 129: how do you define an "elective" cesarean?

Line 133: please provide a reference for healthy people 2020

Around line 137: Please perform the propensity analysis requested by the statistical editor

Line 154; PROVIDE the total number of deliveries then the subset within this study and their assignment to service. Also, avoid beginning a sentence with a numeral.

Line 196" Tool in the belt" is somewhat colloquial. Can you edit?
Rather than just focusing on things that might increase the rates of cesarean births among physician-led services, can you offer some things that midwives are trained in that promote vaginal birth (laboring at home, spontaneous labor, positioning, intrapartum support, neuraxial anesthesia use, etc)

199: we don't use the term "cesarean section" : it's either cesarean birth or delivery.

EDITORIAL OFFICE COMMENTS:

1. 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.

2. 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.

3. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." *The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

4. 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.

5. 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.

6. 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).

7. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

8. 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.

9. 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.

10. 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.

11. 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%").

12. 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.

13. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG 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 (exceptions could include manuscripts that address items of historical interest). 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 an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance.

14. Figure 1 may be resubmitted as-is.

15. 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/ifauth.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.

16. 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 14 days from the date of this letter. If we have not heard from you by Dec 19, 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

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December 19, 2019

Re: Revised submission of manuscript, "Singleton Term Vertex Cesarean Delivery by Midwife Service Compared with an Obstetrician Service"

The Editors

Obstetrics and Gynecology

409 12th Street, SW

Washington, DC 20024-2188

Dear Editors:

Thank you for the opportunity to submit a revised version of this manuscript for consideration for publication as Original Research in *Obstetrics and Gynecology*. All authors participated in writing this manuscript and agree with the final submission. There are no conflicts of interests to report. This manuscript was prepared using the STROBE guidelines.

The study was approved (#28728) by the Dartmouth College Institutional Review Board. The manuscript has not been previously submitted or published, and follows the Journal's instructions for authors. The lead author, Ella Damiano, affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned, have been explained.

There are no acknowledgements. This abstract was submitted for consideration at the 2020 ACOG Annual Meeting however a decision has not been reached on that submission.

Prior to submission, the instructions to authors were reviewed. Please find below our response to reviewers submitted with the revised manuscript.

If you have any questions about the manuscript, I will be serving as the corresponding author. Thank you for your consideration.

Sincerely,

Ella A. Damiano, MD

REVIEWER COMMENTS:

Reviewer #1: Damiano and colleagues present a retrospective cohort study evaluating difference in cesarean delivery rate between a midwifery labor service and an obstetrician-led labor service. I have the following questions/comments for the authors:

1- Please amend the short title as this makes it seem that the midwives are performing cesareans.

Changed short title to comply with formatting and improve clarity as recommended above.

2- The abstract is clear and well-written.

Thank you.

3- Line 63 - The text references "studies" plural but here is only one reference. Please correct.

Added additional citation.

4- The methodology is well described.

Thank you.

5- Line 83 - Are there any patient factors that would make them ineligible for midwifery care at your institution? Many institutions with different delivery services have criteria that exclude patients from lower risk care.

We added exclusion list from the midwifery group.

6- Line 201 - Consider adding malpractice concerns to your possible influences.

Added this to discussion.

7- Line 205 - Describing what you will be tracking in the future seems odd here and does not pertain to the data you are able to present. If you want to show understanding that there is an alternate metric and that that wasn't what you were able to collect, I would rephrase.

We rephrased this sentence and moved it to the limitations since this would have been a better balancing measure for TSV but the measure did not exist at the time of this study design.

8- Tables - Consider bold type for statistically significant p values for ease of reading. The tables are well designed.

Bolded significant results and added footnote to explain the formatting.

Reviewer #2: Dr. Damiano and colleagues performed a retrospective cohort study to determine whether the rate of cesarean delivery differed by Midwifery or Physician led service. Very nice and timely study to highlight how differences in labor management training can be a modifiable factor to reduce the cesarean delivery rate. I recommend consideration to rewording the title to "Singleton Term Vertex Cesarean Delivery in a Midwifery Service Compared with Physician-led Obstetrician Service". Additionally, assessing and reporting differences in neonatal morbidity such as need for respiratory support, NICU admission, meconium aspiration etc. would further strengthen this study.

Changed title to comply with formatting and feedback as above. We also added NICU admission to the study.

Reviewer #3: If I am reading this correctly, you picked the groups based upon the admitting service. Is it not likely that patients were transferred from the midwifery service to the physician service prior to admission? I can imagine diagnoses like gestational hypertension, previa, oligohydramnios and IUGR as possible indications for transfer to physicians (though not necessarily MFM which would have excluded them from analysis?) This certianly would bias the results. You do a nice job of discussing reasons why the patients may be different beyond BMI and medical conditions like SES, labor support, birthing preferences but you don't really address patient culture. It is well described in the literature that patients who choose midwifery care, especially community out of hospital birth patients, have a very different culture more focused upon the birth experience rather than upon statistics and medical risk. Can you address this further in your manuscript? You don't have a very robust measure for outcome beyond Apgar. Could you at least look at NICU admissions or try to develop a composite of Apgar, NICU admission, cord pH, neonatal seizures?

Clarified that provider type is at delivery admission. Discussed that midwives transfer some patients during prenatal care but also retain many higher risk patients for term deliveries (preeclampsia, fetal growth restriction). We further describe that all midwife patients have hospital deliveries. We also added to the discussion that midwife patients self-select and may have different culture when approaching birth preferences. We also added NICU admission as a balance measure in addition to Apgar score.

STATISTICAL EDITOR COMMENTS:

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

Reviewer #4: lines 39-41: These are not odds, but rather frequencies or proportions. The primary outcomes should be stated as n(%) for each cohort, then as aORs with CIs. The primary outcome should be stated first, then all the secondary ones.

Fixed formatting and the order of results.

Table 1: Should include the GA (weeks) for each cohort and include in stats testing at baseline. Should include finer grain detail, such as n(%) of births at each week of GA. Need units for maternal age. Should expand the parity to include information on women with multiple prior births in each cohort, rather than nulliparity only.

Included GA by week in Table 2. Added units as requested. Parity now listed in Table 1 with greater detail.

Table 2: What were the reasons for "elective" cesarean? Was that based on maternal decision or preference?

Added an explanation to both the methods section and a footnote to Table 3.

Table 3: Should clearly separate the primary from the secondary outcomes. Should indicate the statistically significant ORs and aORs by emboldening them (thus eliminating ambiguity when a CI boundary = 1.00). Should indicate in a footnote which variables were retained in the final model. Should indicate whether the referent for age is per 1 year, the referent for BMI is per 1 kg/m^2. Some of the variables (eg, maternal DM or advanced maternal age etc) per Table 2 were relatively infrequent and thus there is likely not enough information to precisely adjust for multiple covariates.

Added primary outcome on Table 3. Bolded significant findings. We added detail regarding referent groups and coefficient interpretation in Tables 3 and 4 as a footnote.

General: Given that the groups were not randomly assigned and that there were baseline differences in demographic variables, and factors cited in Table 2, it would strengthen the Authors' conclusion to perform propensity matching of the two cohorts to corroborate the difference in the primary outcome.

We performed 1:1 propensity score matching and adjusted logistic regression within the matched sample with propensity score weighting. We assessed the balance of propensity scores between groups visually and statistically. As a robustness check, we generated inverse probability of treatment weights (IPTW) and performed adjusted logistic regression with IPTW on the full sample.

EDITOR'S COMMENTS

Line 29: 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.

We have reviewed the instructions to authors and ensured compliance.

Line 31: In methods section, please describe how women are assigned to the MD vs CNM led service. Delete "of 1787" here as it is the results section.

Added this to the abstract. Deleted redundant "1787."

Line 36: Do you between these dates or from these dates? How many total deliveries are there at the hospitals and on the 2 services?

Clarified analysis was between these two dates. We added total deliveries for services during that time to the results section.

It would be best to always present your data in the same order: midwfe vs physician OR physician vs Midwife. The consistency will require a change in use of increased and decreased, but will make it easier for the reader to keep track of what comparisons are being made.

Changed to midwife vs. obstetrician formatting throughout.

P Values vs Effect Size and Confidence Intervals: 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.

Updated to Refer to aOR with CI in manuscript and abstract for Table 3 data. For the bivariate tests (Table 1 and 2) we did not include CI but continue to present p values. We removed p values from several sections of the manuscript and presented confidence intervals alone (adjusted and crude regression results).

Please provide absolute values for variables, in addition to assessment of statistical significance.

We added absolute values.

We ask that you provide crude OR's followed by adjusted OR's for all variables.

Referenced Table 3 for the crude ORs in the results.

Line 42: Virginia Apgar is the source of the word. Its not an acronym so should not be in all caps.

Updated.

Line 45: on line 44 you say you adjusted for "all maternal and delivery characteristics". What do you mean here about "other factors"?

Rephrased sentence for better clarity.

Line 59; WHAT is “routine data”?

Edited to say monthly quality data review

Line 65: should be NTSV or TSV?

After review of the citation, we have confirmed that the paper used a TSV rate.

Line 91: what is providing prenatal care in Pods? Is it relevant where they provide care?

Removed the word Pods since it is unnecessary. This references team-based care (rather than a physical location).

Line 94: are there criteria for risking in and out of midwifery care? What happened if a patient was transferred from one service to the other part way through the pregnancy? What service was she “assigned” to at delivery? What service is “assigned” if a patient is delivered, for instance, by a midwife who was laboring with the MDs who were all tied up in deliveries and couldn’t attend the birth (or vice versa)?

Added exclusion criteria for midwife care and explanation of prenatal or intrapartum transfer.

Line 111: birth weight is problematic here as it is not known until after the birth so its potential influence on intrapartum decision making is nil. Do you have EFW?

EFW is not routinely captured in the EMR. Therefore, we used infant birth weight since it is available for all deliveries. We agree with EFW would impact physician management of labor however the infant weight is relevant to cesarean delivery risk ultimately.

Line116: We use reVITALize terminology now. For instance, this is now prelabor rupture of the membranes. Similarly on line 120, its gestational hypertension, not PIH

Updated.

Line 129: how do you define an “elective” cesarean?

We updated this to reflect that it is upon maternal request.

Line 133: please provide a reference for healthy people 2020

Fixed.

Around line 137: Please perform the propensity analysis requested by the statistical editor

This has been performed.

Line 154; PROVIDE the total number of deliveries then the subset within this study and their assignment to service. Also, avoid beginning a sentence with a numeral.

Added to the results section.

Line 196” Tool in the belt” is somewhat colloquial. Can you edit?
Rather than just focusing on things that might increase the rates of cesarean births among physician-led services, can you offer some things that midwives are trained in that promote vaginal birth (laboring at home, spontaneous labor, positioning, intrapartum support, neuraxial anesthesia use, etc)

Updated discussion to include this feedback.

199: we don’t use the term “cesarean section” : it’s either cesarean birth or delivery.

Updated.

EDITORIAL OFFICE COMMENTS:

1. 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. Agree with this statement.

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

2. 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.

No disclosures for any authors.

3. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." *The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

This is included in the cover letter as requested.

4. 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.

We have used revitalize definitions.

5. 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.

Compliant with page and word limit.

6. 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).

We have submitted an abstract to the Annual ACOG meeting however we have not be notified of results and therefore, it is not currently mentioned in the submission.

7. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

Precis meets these requirements.

8. 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.

This has been double-checked prior to submission.

9. 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.

Eliminated abbreviations that are not on the approved list.

10. 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.

Virgule symbol has not been used.

11. 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%").

Standardized data prior to submission. Effect size included when available.

12. 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.

Table checklist was reviewed prior to submission.

13. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG 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 (exceptions could include manuscripts that address items of historical interest). 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 an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance.

Cited ACOG document is current.

14. Figure 1 may be resubmitted as-is.

Re-submitted as is.

15. 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/ifauth.htm.

We would decline open access publication.