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: Apr 10, 2020
To: "Gregory Matthew Gressel" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-457

RE: Manuscript Number ONG-20-457

Resident and program director confidence in resident surgical preparedness in obstetrics and gynecologic 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).

Due to the COVID-19 pandemic, your paper will be maintained in active status for 30 days from the date of this letter. If we have not heard from you by May 10, 2020, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: The authors present a reasonably well written survey manuscript on preparedness of residents as well as impressions or residency program directors. Overall this was a well executed survey study that raises several questions as to the clearly discrepant nature of resident self perception as well as program director perception of resident competencies.

1. Lines 69-70: I would include that general surgery data from Mater et al in JACS concluded similar findings.

2. Line 72- is this really necessary? I would avoid self-citation

3. The introduction is globally, poorly written. Other than self citation and brief review of the data, the authors should expound upon why the study that has been conduction is relevant vis-a-vis previous data.

4. Lines 85-86: There is substantial bias in the study design given that it is a self- assessment. Did they authors utilize any validated tools to help mitigate this bias?

5. It appears that all resident years were included. I would consider breaking out R4 and R1 separately; what is the real utility in asking an intern to assess their competency?

6. Fundamental question: Your data deviates substantially from previous data by Doo et al and Guntupalli et al in which resident skill set was far poorer than what is presented. What is the reason for this? Is this the bias that I have previously alluded too?What are the implications of this highly divergent opinions?

7. Line 134: What did so many opt out of this questionaire? What was there not to understand? How was consent to participate established and what were the exact question used? I am concerned that you are missing a decent amount of data here and this should be added as a critique of your study.

8. Line 171-173: I would expand upon this in the discussion. Residents are self identifying that VH is a weakness yet program directors are saying they are competent. This is not surprising and expected given the pressures placed on program directors to show competency.

9. Line 184: In what conditions would you ever need to perform an emergent operative hysteroscopy? I would remove this as it seems superfluous.

10. Line 266: Please reword this sentence and take out our from the plural possessive as this is not appropriate for

scientific writing.

Reviewer #2: *should stratify community vs university programs in data analysis . . which type of program has a richer surgical experience.

strongly suggest to leave off data about junior residents. the key is how residents who are about to finish feel.
should include data as to whether female residents feel more comfortable than male resdients. (especially large programs for internal comparison)

Line 58 thru 59 worded awkwardly.

line 63 i recommend "be eligible" instead of sit

consider repeating this type of study for those taking the "written " abog exam at the end of the residency.
offer suggestions on how to close the gap between resident and program director perceptions on preparedness. i.e. simulation , watching surgical videos in group settings with attending guidance,
community hospital rotations etc

comment on why you would think 100% of program directors dont feel that residents are competent to perform vacuum delivery or other operatve delivery. was there a separate question about forceps? i would opine that all residents should be competent in this area unless clearly identified to matriculate into gynonc, rei or min invasive surgery.

were the questions given at the beginning or at the end of the creog exam? if at the end then the resident may have been fatigued. a good time would be a the end of the morning exam book.

consider dropping those who had neutral response from data evaluation. Lines 117-9. unfair to arbitrarily lump into the not prepared category.

what is an emergent vaginal hysterectomy. ? is it a pertinent question. i may have performed two in my 20+ yr career

a more appropriate question would be preparedness for c-hyst or post partum hyst

*consider including statement that vaginal hysterectomy should be dropped as a requirement. medical rx and ablative procedures will drastically reduce candidates for this procedure. too many program directors and residents seem to feel that residents are not prepared. table 3 and 4

do all residents need to be competent to perform all the listed procedures. ? prob not. consider to make recommendation.

lastly consider a statement that surgical education and mentorship should extend one or two years beyond residency especially for those not considering fellowship. individual hospitals and health care systems should set criteria for competence based on case logs.

Reviewer #3:

Abstract was clear and concise.

Introduction: Laid out clearly what we know and goals of study.

Materials and methods: Laid out clearly. Survey study looking at self-reported confidence levels compared to responses from program directors.

Results were straightforward as were statistics.

Discussion: Clear, some speculation in differences between this and previous data.

Conclusions: Follow from the data.

Graphs: Relatively straight forward

This article summarizes survey data from residents at various levels of training and compares to opinions of program

directors. The data is interesting in the face of how many people now question competence at graduation. The difference between resident self-assessment and program director assessment may also be due to when the CREOG exam is given. This is not addressed.

STATISTICAL EDITOR COMMENTS:

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

lines 134-135: "Attempted to take the survey" is not a useful descriptor. Should include a flow diagram and summarize that 5137 (92.9% took the survey. Should also enumerate any missing data from individual questions, just as the Other or no response answers were formatted in Table 1.

Table 3: The p-values are not needed, since the ORs each have CIs.

Table 4: Not convinced that the ORs are necessary to convey the idea of increasing preparedness vs PGY-level. Suggest instead including CIs for each proportion, then a chi-square test for trend for each procedure. I believe that would more concisely and directly convey the concept of increasing preparedness vs PGY-level for the procedures. That is, not convinced that ORs are that clinically useful in this context.

EDITOR'S COMMENTS:

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 ad other relevant topics. Adherence to these requirements with your revision will avoid delays during the revision process by avoiding re-revisions on your part in order to comply with formatting.

Numbers below refer to line numbers.

39 and elsewhere:
PRESENTATION OF STATS INFORMATION (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 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, tables, and figures.

Please provide absolute values for variables, in addition to the assessment of statistical significance. Providing p values alone is insufficient.

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

Please limit p values to 3 decimal places.

58. Do not begin a sentence with a numeral. Either spell out or edit your sentence to avoid the need to start w/ a number.

63. My 7th grade English teacher made us diagram sentences. I loved it and it probably was a foreshadowing of this current role as Editor. If you diagram this sentence, it's the program directors who are sitting for ABOG exam. Can you rewrite?

119: Do you mean that they were excluded from the entire analysis if they missed even 1 question?

135: what do you mean "attempted to complete the survey"?

140: how did you manage the comparisons between resident and PD results if the PD didn't complete the survey?

146: How do you mean “most” if these percentages are < 50%?

148: ACOG prefers to avoid the term “generalist” in favor of “Specialist”. Not sure about the dichotomy between become generalist OR entering private practice. I would suspect that most residents planning on becoming a specialist in OB GYN will enter private practice rather than academics.

152: Perinatology is not really the term anymore., In fact, I think the neonatologists have claimed it.

156: as noted above, please provide absolute data as well as OR's and 95% CI's. You can omit p values.

174: In the discussion section, please comment on whether you think there is a relevant difference between 93 and 97%. Given the large N of residents, I suspect you achieved a significant difference, but not clear if it's relevant.

187: Numeral at the start of the sentence; please edit.

190. Do use single-sentence paragraphs.

Lines 195-206 are really just repetition of your results. Is there a more global conclusion you can make as the lead into your introduction that relates to your primary outcome? Were the 2 procedures in your first sentence the most important so that you've highlighted them by putting them first? Your discussion should lead with your primary outcome and some sort of global statements that help set up the rest of your discussion.

228: Is a junior resident a PGY1-2?

Tables: You can delete the p-value columns

One reviewer suggests leaving out an analysis of residents PGY1-3. I disagree with this and think including them is fine. I do think a comparison of PGY4 data from community vs academic programs might be of interest.

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. 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.

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. Titles in Obstetrics & Gynecology are limited to 100 characters (including spaces). Do not structure the title as a declarative statement or a question. Introductory phrases such as "A study of..." or "Comprehensive investigations into..." or "A discussion of..." should be avoided in titles. Abbreviations, jargon, trade names, formulas, and obsolete terminology also should not be used in the title. Titles should include "A Randomized Controlled Trial," "A Meta-Analysis," or "A Systematic Review," as appropriate, in a subtitle. Otherwise, do not specify the type of manuscript in the title.

7. 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).

8. Provide a short title of no more than 45 characters, including spaces, for use as a running foot.

9. 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.

10. 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.

12. 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.

13. 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%").

14. 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.

15. Figures 1-2: Files may be resubmitted as-is.

16. 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.

17. 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 30 days from the date of this letter. If we have not heard from you by May 10, 2020, 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

_____

[redacted]

April 27th, 2020

Nancy C. Chescheir, MD
Editor-in-Chief
409 12th Street, SW
Washington, DC 20024
obgyn@greenjournal.org

Dear. Dr. Chescheir and Expert Reviewers,

Thank you for your very thorough review of our manuscript "Resident and program director confidence in resident surgical preparedness in obstetrics and gynecologic training programs." As the primary author of this original study, I truly appreciate your consideration of manuscript for publication in *Obstetrics & Gynecology*. Please see below our point-by-point responses to your comments in red font. If you require any additional materials from us or have any questions about our submission, please feel free to contact me. We feel our findings will inform residency educators and governing bodies at a time when surgical numbers are particularly at risk in residency programs. Thank you for your consideration and we look forward to hearing from you.

Yours gratefully,

Erika Banks, MD

REVIEWER COMMENTS:

Reviewer #1: The authors present a reasonably well written survey manuscript on preparedness of residents as well as impressions or residency program directors. Overall this was a well-executed survey study that raises several questions as to the clearly discrepant nature of resident self perception as well as program director perception of resident competencies.

Thank you for your kind comments and review of our paper.

1. Lines 69-70: I would include that general surgery data from Mater et al in JACS concluded similar findings.

We have not been able to find the article you refer to. The only journal we can find that is JACS is the *Journal of the American Chemical Society*? A search within their website for the author "Mater" returns 5686 search results, none of which appear to relate to this topic. Similarly, Google and Pubmed searches were not helpful in finding the reference you're referring to. If you are able to provide us with a PMID for the citation, we would be happy to review the article and if appropriate, may be willing to cite it in our manuscript.

2. Line 72- is this really necessary? I would avoid self-citation

In citing a paper that we recently published, we were certainly not trying to selfishly or nepotistically promote our own work. Rather we were striving to frame the data we present on resident surgical confidence in the context of recent changes in resident surgical numbers. We feel the data in that citation informs the data presented in this paper and is relevant to the conversation at hand.

3. The introduction is globally, poorly written. Other than self-citation and brief review of the data, the authors should expound upon why the study that has been conduction is relevant vis-a-vis previous data.

According to the *Obstetrics & Gynecology "Instructions for Authors."* (http://edmgr.ovid.com/ong/accounts/authors.pdf), The Introduction section "Orients the reader to the problem(s) addressed by the report, preferably in one page or less, and clearly states the hypothesis or objective of the research. Avoid a detailed literature review in this section." We feel that we have done just that. We have reserved a comprehensive discussion of extant literature for the "Discussion and Significance" section. This comment differed from reviewer 3 who specifically liked the introduction.

4. Lines 85-86: There is substantial bias in the study design given that it is a self- assessment. Did they authors utilize any validated tools to help mitigate this bias?

Research bias is systematic error introduced into sampling or testing by selecting or encouraging one outcome over another (PMID 20679844). This study was not attempting to measure resident "competence" to perform surgical procedures. If it was, we might introduce response bias or social desirability bias by asking residents to assess their confidence in performing surgical procedures. However as stated in lines 81-83 "The primary goal of this study was to assess residents' confidence and readiness for independent performance of the core surgical obstetric and gynecologic procedures by the time of graduation." There is no other way to measure resident confidence without self-assessment. Regarding use of "validated tools": this survey was developed using literature on surgical confidence and autonomy both inside and outside our field using the Delphi method as mentioned in lines 109-111.

5. It appears that all resident years were included. I would consider breaking out R4 and R1 separately; what is the real utility in asking an intern to assess their competency?

Understanding that this is a cross-sectional survey and that we are not able to report how an individual resident's confidence "changes" over time, we feel it is helpful to see in this cohort differences in perceived readiness between PGY years. In light of this and the comments by the Editor below, we have chosen to include this data.

6. Fundamental question: Your data deviates substantially from previous data by Doo et al and Guntupalli et al in which resident skill set was far poorer than what is presented. What is the reason for this? Is this the bias that I have previously alluded too?What are the implications of this highly divergent opinions?

We addressed this divergence in our findings from those of other studies such as Dr. Guntupalli's study in lines 264-267. We feel this is likely due to a difference between the "competence" a surgical fellowship

program director expects of a new surgical fellow and that which a residency program director's expects of all residents at graduation. Further, the bar for surgical skills confidence in a starting gynecologic oncology fellow is likely to be different from that of a graduating resident going into generalist practice.

7. Line 134: What did so many opt out of this questionnaire? What was there not to understand? How was consent to participate established and what were the exact question used? I am concerned that you are missing a decent amount of data here and this should be added as a critique of your study.

Only 41 of the 5514 examinees who took the 2019 CREOG exam didn't initiate the survey- we clarified this in lines 137-139. We don't know why they left the survey blank. Maybe they left the examination room prematurely or chose not to fill in any of the answers. But a 99.3% response rate is much higher than the widely accepted >80% response rate for survey studies (PMID 18483608). As mentioned in lines 139-140 the first question on the survey asked for consent to use their data for research purposes. The full question was "By checking the box below, I affirm that I understand that the CREOG survey is voluntary and anonymous. Survey responses are NOT linked to individual personal information, nor are they provided to individual program directors. The demographics and answer selections may be used by CREOG and/or other organizations for educational research or similar purposes and may be distributed as scholarship on the topic." We have included this statement in Supplementary Figure 1. Supplementary figure 3 illustrates those who didn't complete the survey and those who did not check the box stating understanding of or agreement with the use of data.

8. Line 171-173: I would expand upon this in the discussion. Residents are self identifying that VH is a weakness yet program directors are saying they are competent. This is not surprising and expected given the pressures placed on program directors to show competency.

We have expanded upon this in lines 209-215 by explaining that residency program directors themselves probably trained during a time where hysterectomies were more commonly performed via a vaginal approach.

9. Line 184: In what conditions would you ever need to perform an emergent operative hysteroscopy? I would remove this as it seems superfluous.

We were striving to assess confidence in surgical independence. After much discussion with surgical educators in our field and general surgery, we asked about confidence in performing each of the surgical procedures "in an emergency" as a proxy for "if you really had to do it independently now without supervision (because it was an emergency)." We clarified this in the text lines 125-127.

10. Line 266: Please reword this sentence and take out our from the plural possessive as this is not appropriate for scientific writing.

Thank you, we have reworded this.

Reviewer #2: *should stratify community vs university programs in data analysis . . which type of program has a richer surgical experience.

Thank you for your careful review of our paper. The survey we administered has generated mountains of data about surgical confidence and autonomy. Amongst other topics, we are writing a separate paper with subgroup analyses describing variability in resident preparedness by gender, CREOG region and residency program type (community vs. academic programs). We agree this is interesting and important information, but we feel it would be too much information to include in this one paper.

strongly suggest to leave off data about junior residents. the key is how residents who are about to finish feel.

If we are to look at "tracking" as a viable option in resident education, it will be important to have some data on when in residency each PGY gains confidence in their ability to perform each core surgical procedure. For example, our data suggests we may not need a 4 year residency for trainees to feel confident in operative hysteroscopy. Further, understanding that this is a cross-sectional survey and that we are not able to report how an individual resident's confidence "changes" over time per se, we feel it is helpful to see in this cohort differences in perceived readiness between PGY years. In light of this and the comments by the Editor below, we have included this data.

should include data as to whether female residents feel more comfortable than male resdients. (especially large programs for internal comparison)

The survey we administered has generated mountains of data about surgical confidence and autonomy. Amongst other topics, we are considering writing a separate paper with subgroup analyses describing variability in resident preparedness by gender, CREOG region and residency program type (community vs. academic programs) but we feel it would be too much information to include in this one paper.

Line 58 thru 59 worded awkwardly.

Thank you, we hope we have clarified this by splitting this sentence into two separate sentences

line 63 i recommend "be eligible" instead of sit

Thank you… changed

consider repeating this type of study for those taking the "written " abog exam at the end of the residency.

Excellent suggestion! Thank you.

offer suggestions on how to close the gap between resident and program director perceptions on preparedness. i.e. simulation , watching surgical videos in group settings with attending guidance, community hospital rotations etc

We have incorporated these suggestions into the discussion section paper: Lines 215-218

comment on why you would think 100% of program directors dont feel that residents are competent to perform vacuum delivery or other operative delivery. was there a separate question about forceps? i would opine that all residents should be competent in this area unless clearly identified to matriculate into gynonc, rei or min invasive surgery.

We suspect that this is due to the relative decrease in use of operative delivery and the relative increase in use of cesarean delivery over time. Additionally, since they are less common, faculty may not allow their residents autonomy performing vacuums in emergent situations, reserving this procedure for MFM fellows or performing them themselves. There was a separate question about forceps, but the data on forceps was even more concerning. The confidence in this procedure was so low and regionally variable that we felt it merited a separate manuscript on operative delivery, which we are currently drafting.

were the questions given at the beginning or at the end of the creog exam? if at the end then the resident may have been fatigued. a good time would be a the end of the morning exam book.

Exactly as you suggested the questions were given at the end of the morning exam.

consider dropping those who had neutral response from data evaluation. Lines 117-9. unfair to arbitrarily lump into the not prepared category.

This is really a question of semantics. The reason we used a likert scale was to get an idea of how prepared someone is on a spectrum between "completely unprepared" and "totally prepared". But ultimately, it is a dichotomous issue. Either someone feels prepared or they feel less than prepared. Where you draw the line does become arbitrary and depends on how the study is designed. Our reasoning is that people who responded "neutral" were likely "not entirely confident" about their surgical preparedness and this might be a metric of "lack of confidence" in performing an emergent surgery (or a proxy for lack of surgical independence).

what is an emergent vaginal hysterectomy. ? is it a pertinent question. i may have performed two in my 20+ yr career

While a clinical scenario in which you need to emergently remove a uterus via a vaginal approach is likely rare, "emergent" in this situation refers to a resident's perceived ability of performing a vaginal hysterectomy quickly, safely, efficiently and perhaps independently. For example: What if you were to start a vaginal hysterectomy and encounter a lot of bleeding during the procedure? Your options might be to very quickly or "emergently" complete the hysterectomy vaginally or convert to open. This was also a proxy for surgical independence (if you had to, and there wasn't an experienced attending present).

a more appropriate question would be preparedness for c-hyst or post partum hyst

This would have been a great question to ask but unfortunately it wasn't included in this particular survey. We did ask about emergent abdominal hysterectomy, so this may help address this point.

*consider including statement that vaginal hysterectomy should be dropped as a requirement. medical rx

and ablative procedures will drastically reduce candidates for this procedure. too many program directors and residents seem to feel that residents are not prepared. table 3 and 4

We feel this might be an over-reaching conclusion from our data. We agree that the fact that residents and PD lack confidence in resident's abilities to perform this procedure is concerning. However, vaginal hysterectomy is still recommended as the safest and most minimally invasive and the preferred approach if feasible. Maybe not ALL residents need to be competent to perform ALL procedures, especially if they are going into subspecialty practice. We have included this in the paper in lines: 238-251

do all residents need to be competent to perform all the listed procedures. ? prob not. consider to make recommendation.

Based on your advice, we have included this in lines: 238-251

lastly consider a statement that surgical education and mentorship should extend one or two years beyond residency especially for those not considering fellowship. individual hospitals and health care systems should set criteria for competence based on case logs.

Thank you, we have added this to lines 246-251

Reviewer #3:

Abstract was clear and concise.

Introduction: Laid out clearly what we know and goals of study.

Materials and methods: Laid out clearly. Survey study looking at self-reported confidence levels compared to responses from program directors.

Results were straightforward as were statistics.

Discussion: Clear, some speculation in differences between this and previous data.

Conclusions: Follow from the data.

Graphs: Relatively straight forward

This article summarizes survey data from residents at various levels of training and compares to opinions of program directors. The data is interesting in the face of how many people now question competence at graduation. The difference between resident self-assessment and program director assessment may also be due to when the CREOG exam is given. This is not addressed.

Thank you for your kind comments and your review of our manuscript. We are confused as to what you mean by "may be due to when the CREOG exam is given." If you mean that differences in perceived

readiness might be related to temporal differences in survey administration to residents versus program directors, we can confirm that program directors were emailed surveys at the same time residents took the CREOG exam and the program directors completed those surveys within days of the residents' completion of the same. We have clarified this in lines 111-114.

STATISTICAL EDITOR COMMENTS:

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

lines 134-135: "Attempted to take the survey" is not a useful descriptor. Should include a flow diagram and summarize that 5137 (92.9% took the survey. Should also enumerate any missing data from individual questions, just as the Other or no response answers were formatted in Table 1.

Thank you for your comments. We have clarified that 41 examinees left the survey entirely blank, included a flow diagram regarding data included in the analysis, and included a figure detailing number and percent of non-responders for each question. Lines 137-147. Supplementary Figures 3 and 4.

Table 3: The p-values are not needed, since the ORs each have CIs.

Thank you we removed P values.

Table 4: Not convinced that the ORs are necessary to convey the idea of increasing preparedness vs PGY-level. Suggest instead including CIs for each proportion, then a chi-square test for trend for each procedure. I believe that would more concisely and directly convey the concept of increasing preparedness vs PGY-level for the procedures. That is, not convinced that ORs are that clinically useful in this context.

Thank you for this suggestion. Not surprisingly the p values for test-for trend for surgical preparedness over time are all less than 0.01, which is what the p-values for the regression are. Unweighted chi-squared tests for trend are basically a Pearson's correlation coefficient. We feel that including the odd-ratios at least give an idea of the magnitude of difference for each PGY year relative to interns. We have indicated in the methods section that we have done a chi-square test for trend for each procedure (Line 132-134), replaced the column of p-values with p-values for test of trend (the same) and indicated in the manuscript that the test for trend was $p < 0.01$ for each procedure (Line 195-196).

EDITOR'S COMMENTS:

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 ad other relevant topics. Adherence to these requirements with your revision will avoid delays during the revision process by avoiding re-revisions on your part in order to comply with formatting.

Dr. Chescheir, thank you for reviewing our paper. We have read your "Instructions for Authors" and we believe we have adhered to the Green Journal's format for original research

Numbers below refer to line numbers.

39 and elsewhere:
PRESENTATION OF STATS INFORMATION (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 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, tables, and figures.

Please provide absolute values for variables, in addition to the assessment of statistical significance. Providing p values alone is insufficient.

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

Thank you- we have made these changes throughout the paper except for where odds ratios were incalculable (where 100% of program directors reported residents could perform cesarean delivery and operative deliveries, we have simply stated that the p value is > 0.90).

Please limit p values to 3 decimal places.

Thank you- we have made these changes throughout the paper.

58. Do not begin a sentence with a numeral. Either spell out or edit your sentence to avoid the need to start w/ a number.

We have changed this in all circumstances

63. My 7th grade English teacher made us diagram sentences. I loved it and it probably was a foreshadowing of this current role as Editor. If you diagram this sentence, it's the program directors who are sitting for ABOG exam. Can you rewrite?

Excellent point. Thank you. We hope the rewording sounds better: Lines 60-63

119: Do you mean that they were excluded from the entire analysis if they missed even 1 question?

No! Thank you for clarifying. We have split the comment into two sentences. The first clarifies that participants who didn't provide consent were excluded from the entire analysis. The second clarifies that

participants who didn't answer an individual question were excluded from analysis of that question. Lines 118-120

135: what do you mean "attempted to complete the survey"?

By this we mean that they answered any question at all. We have clarified to indicate that 41 examinees left the survey entirely blank. At the suggestion of the statistical editor, we also included a supplementary flow diagram for who completed the survey and who was analyzed. Supplementary Figure 3; Lines 137-139

140: how did you manage the comparisons between resident and PD results if the PD didn't complete the survey?

This is an important point to clarify. Data collected from program directors was analyzed as a group and was not linked to data from individual residents within each program. We have included this information in lines 114-115.

146: How do you mean "most" if these percentages are < 50%?

We had meant that these categories represented the majority of the population compared with respondents from Military Programs or Combined university and community-based programs (as mentioned in table 1). We have clarified in lines 150-152 to simply state that "Forty-six percent of residents and 47% of program directors were from university-affiliated academic programs."

148: ACOG prefers to avoid the term "generalist" in favor of "Specialist". Not sure about the dichotomy between become generalist OR entering private practice. I would suspect that most residents planning on becoming a specialist in OB GYN will enter private practice rather than academics.

We have changed the term "generalist" throughout the paper to "specialist in general obstetrics and gynecology."

152: Perinatology is not really the term anymore., In fact, I think the neonatologists have claimed it.

Thank you we have changed this to "maternal fetal medicine subspecialists." Line 156-158.

156: as noted above, please provide absolute data as well as OR's and 95% CI's. You can omit p values.

Thank you, we have removed all P values from the manuscript with the exception of where odds ratios were unable to be calculated (when PD's reported 100% of their residents could competently complete a procedure), or when chi-squared tests of trend are reported. At the suggestion of the statistical editor, we included p-values only for chi-squared tests of trend which is <0.01 for each procedure listed.

174: In the discussion section, please comment on whether you think there is a relevant difference between 93 and 97%. Given the large N of residents, I suspect you achieved a significant difference, but not clear if it's relevant.

Excellent point. We have mentioned this in lines: 205-208

187: Numeral at the start of the sentence; please edit.
Changed.

190. Do use single-sentence paragraphs.

Changed.

Lines 195-206 are really just repetition of your results. Is there a more global conclusion you can make as the lead into your introduction that relates to your primary outcome? Were the 2 procedures in your first sentence the most important so that you've highlighted them by putting them first? Your discussion should lead with your primary outcome and some sort of global statements that help set up the rest of your discussion.

We reviewed the discussion and agree. Your comments here particularly are precise, helpful and most appreciated. We reorganized the order of the discussion as suggested. We feel your comments have helped us clarify our discussion and we are most grateful.

228: Is a junior resident a PGY1-2?

Yes that is what we had meant, but we changed this to spell out implicitly which years we meant.

Tables: You can delete the p-value columns

We deleted p values from Table 3 and at the suggestion of the statistical editor, have included p-values for chi-squared test of trend for each procedure in Table 4.

One reviewer suggests leaving out an analysis of residents PGY1-3. I disagree with this and think including them is fine. I do think a comparison of PGY4 data from community vs academic programs might be of interest.

Thank you. We left in the analysis stratified by year. The survey we administered has generated mountains of data about surgical confidence and autonomy. Amongst other topics, we are considering writing a separate paper with subgroup analyses describing variability in resident preparedness by gender, CREOG region and residency program type (community vs. academic programs) but we feel it would be too much information to include in this one paper. We are looking at comparing CREOG regions as it aligns with community/ academic program data and ACGME case numbers by CREOG region as well.

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.

OPT-IN: Yes please 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.

We have no disclosures to report.

3. 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.

We have mentioned that the American College of Obstetricians and Gynecologists (ACOG) institutional review board reviewed and approved this study: Lines 88-89

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://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%7Cggressel%40montefiore.org%7C0162e66751bf4b5186db08d7dd56fc6b%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C0%7C637221239185310926&sdata=zjKFKUOu0qtwW3vTlbnz9OnC%2BvzDmSebENPV05bC5e8%3D&reserved=0. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

We have done this.

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.

Our abstract falls within these guidelines.

6. Titles in Obstetrics & Gynecology are limited to 100 characters (including spaces). Do not structure the title as a declarative statement or a question. Introductory phrases such as "A study of..." or "Comprehensive investigations into..." or "A discussion of..." should be avoided in titles. Abbreviations, jargon, trade names, formulas, and obsolete terminology also should not be used in the title. Titles should include "A Randomized Controlled Trial," "A Meta-Analysis," or "A Systematic Review," as appropriate, in a subtitle. Otherwise, do not specify the type of manuscript in the title.

7. 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 no acknowledgements to report.

8. Provide a short title of no more than 45 characters, including spaces, for use as a running foot.

Resident Surgical Confidence Survey

9. 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 do not believe there are any discrepancies

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.

286

10. 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%7Cggressel%40montefiore.org%7C0162e66751bf4b5186db08d7dd56fc6b%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C0%7C637221239185320927&sdata=mP2Kq8oRCAmKqDQpldIzMSvygqpNnYSBIrbC99rd8dM%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.

The only abbreviations we have used consistently are ACOG, ABOG, ACGME and CREOG. We have spelled these abbreviations the first time they were used and carried the abbreviations throughout the text. Writing the full name of these organizations repeatedly would be prohibitively long.

12. 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 no virgule symbols.

13. 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%").

We have changed these things.

14. 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%2Facc

ounts%2Ftable_checklist.pdf&data=02%7C01%7Cggressel%40montefiore.org%7C0162e66751bf4b5186db08d7dd56fc6b%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C0%7C637221239185320927&sdata=FpMXh%2BMCk%2FnaAtqxUmLNX3KHGpo2FKZop9mU738fzow%3D&reserved=0.

We believe our tables meet the guidelines.

15. Figures 1-2: Files may be resubmitted as-is.

Thank you.

16. 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%7Cggressel%40montefiore.org%7C0162e66751bf4b5186db08d7dd56fc6b%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C0%7C637221239185320927&sdata=f24fra5rkSzW0y9ijNL23%2FDjr%2FC1MipqDKEV5kC%2Fx1k%3D&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%2Facd%2Faccounts%2Fifauth.htm&data=02%7C01%7Cggressel%40montefiore.org%7C0162e66751bf4b5186db08d7dd56fc6b%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C0%7C637221239185320927&sdata=gI5a1OZBdFX%2Bk%2Fup8f1OdJDck6vOFUHckS4NtcmMK9A%3D&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.

Traditional processing please.

17. 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%2F&data=02%7C01%7Cggressel%40montefiore.org%7C0162e66751bf4b5186db08d7dd56fc6b%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C0%7C637221239185320927&sdata=lGC0KsC7ECTtmV0%2BvAaZolUqKTqs7RM7Z1JV0JKuiYw%3D&reserved=0. 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 (https://nam04.safelinks.protection.outlook.com/?url=http%3A%2F%2Fedmgr.ovid.com%2Fong%2Faccounts%2Fauthors.pdf&data=02%7C01%7Cggressel%40montefiore.org%7C0162e66751bf4b5186db08d7dd56fc6b%7C9c01f0fd65e040c089a82dfd51e62025%7C0%7C0%7C637221239185320927&sdata=dlZ1ElKc4z6X1l3CtJVdu63rsejYeP5AynK5jV4HT%2B8%3D&reserved=0), and
* A point-by-point response to each of the received comments in this letter.

We confirm we have read the instructions for authors.