Date: Oct 19, 2018
To: "Daniel Grossman" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-18-1708

RE: Manuscript Number ONG-18-1708

Induced abortion provision among a national sample of obstetrician-gynecologists

Dear Dr. Grossman:

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

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

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Nov 09, 2018, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

REVIEWER #1:

This is a mailed survey study to report on the proportion of OBGYNs who provide abortion care and to explore barriers to provision of medication induced abortion.

Main issues:

1- Response rate was calculated to be 71% based on receiving 698 responses from 980 sample and of those reported as responders, 43 were excluded for either retiring or because they did not want to participate in the survey. Those who refused to participate should also be labeled as "non-responders" which would reduce the response rate. Please include the actual numbers and include a figure with all the stipulation reported in method section and results

2- Identifying the proportion of OBGYNs who provide abortion services is the main objective of this study. So, it is very important to determine the denominator used and how representative that is of the target population which is the US OBGYN physicians. Please include clearly the selection process from the target population to those included in the final analysis for that specific aim.

3- Because of the lower response rate to the survey (< 85%) and the nature of this research, non-responders bias is a potential threat to the internal validity of the study. Please compare available date (e.g. demographic, geographic, etc) between responders and non-responders.

Specific points:

4- Introduction: Well written

5- Methods:
a. Line 80-89: Please move the information about the sampling and numbers to the results.
b. What was the method used to improve the response rate?
c. Did the authors use the same method for calculating the proportion of OBGYNS providing abortion services? This is important for the readers to understand if the new reported proportion has changed from the last survey 2008-09.

6- Results:
a. Please consider adding another table comparing demographic characteristics between physicians who responded and those who did not respond.

b. Line 173: The interaction between the gender and geography is very interesting and might need more emphasis in the discussion.

7- Discussion:
a. Line 273: please provide the generic name and company for Mifeprex
b. Please address the low response as a weakness of the study and comment on efforts to increase response and to address non-responder bias.

8- Tables and Figures:
a. Please consider adding a figure to report the selection process for participating physicians starting from the total number of OBGYN in the US to the final number included in the analysis for the primary aim which is the proportion of physicians who provide abortion services.

REVIEWER #2:

This is a cross-sectional study describing abortion provision among a national sample of obstetrician-gynecologists who are members of ACOG. This manuscript provides relevant information but manuscript can be edited in length and more focused. Also, use active voice when possible (example, lines 36-38).

Precis

1. Why is "practice setting" highlighted in the précis since it didn't differ between those who did and didn't provide abortions.

2. The authors also write that medication abortion provision might increase if physicians could prescribe the medications. While this may be true, table 4 shows other more frequently reported reasons than the actual provision of medical abortion (such as lack of training). Furthermore, the ability to prescribe medications is different from a patient actually being able to obtain the medications at a pharmacy, which we know with emergency contraception. Instead, consider modifying précis to something like: "Abortion provision varies by geography among obstetrician-gynecologists; while multiple barriers to medication abortion exist, the option for physician prescribing may facilitate medication abortion provision."

Introduction

3. Lines 65-66: Clarify statement re: characteristics of OBGYNS more likely to provide abortions. Is it female physicians who live in an urban area or Jewish were more likely to provide?

4. Lines 75-77: Add the word "abortion" after medication

Methods

5. This section is almost 4 pages of text, which seems long for describing a survey study. Could the authors consider including a copy of the survey as supplemental material and summarize the questions (instead of including the entire question, example 121-124)?

6. Lines 87-89: The lines regarding the 20 who were excluded should be part of the results. Consider putting inclusion/exclusion criteria for the survey participants in this section instead.

Results

7. This section (3 pages in length) can be shortened since the data are presented in the text and tables.

8. The determination of the response rate is confusing. 1000 CARN members were randomly selected. 18 were not ACOG members or no longer in practice; 2 were unreachable by mail leaving 980 potential participants. 698 then responded to the survey, but of those 43 were excluded because they did not want to participate or were retired. How are these 43 different from the18 who were not ACOG members or no longer in practice? Also, why are the authors counting those who do not want to participate in the response rate?

It seems like the response rate should be the total # of usable responses (n=655) over a denominator of all who were sent the survey (n=1000) or all who would have been eligible for the survey (1000 - [those who had retired +/- those unreachable by mail]). Those who chose not to participate should be included among the non-responders.

Discussion

9. Comment on whether these 1000 sampled in the CARN are representative of ACOG members (demographics etc).

Tables

10. Table 2: In the first row, move the overall "provided any induced abortion" to the top line and indent the subsequent

lines.

11. Table 3: Why give median and mean. The numbers are very different, likely not normal distribution. Give median and range instead.

REVIEWER #3:

This is a overall concise well-written manuscript conveying the results of a survey of ACOG fellows and junior fellows. The purpose of the survey was to estimate the proportion who provided induced abortion in the prior year, and identify barriers to provision. The survey design, and analysis are appropriate. The results and tables are cleanly written and concise.

I would recommend the authors expand on the limitations section of the discussion: Provide more detail on how nonparticipation bias could skew the results.

The sentence on Line 283-286 is wordy and difficult to interpret.

STATISTICAL EDITOR'S COMMENTS:

The overall response rate is good, but for the subsets "Region" or "Practice location", which were correlated with abortion provision, what were the response rates? If there were any selective differences, could those have affected the analysis? Was there a disproportionate distribution of responses to the long survey?

Table 1: Should include a column of unadjusted ORs to contrast with aORs. The aOR estimate could be consolidated into one column with its CIs. The p-values are redundant, since CIs are cited. Could indicate with footnote the significant p-values if desired. Should indicated in footnote to table the variables included in the final adjustment model. (apparently just age and gender, but should be explicitly stated)

Table 3: Should include measure of variability: SD for means and range or IQR for medians.

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, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
   1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
   2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

2. 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.

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

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 will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at http://links.lww.com/AOG/A515, and the gynecology data definitions are available at http://links.lww.com/AOG/A935.

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 appendixes).

Please limit your Introduction to 250 words and your Discussion to 750 words.

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

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

7. 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.

8. 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.

9. 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.

10. 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.

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

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

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

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Nov 09, 2018, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

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

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November 16, 2018

Nancy C. Chescheir, MD
Editor-in-Chief
Obstetrics & Gynecology

Dear Dr. Chescheir,
Thank you for the opportunity to revise our manuscript entitled “Induced abortion provision among a national sample of obstetrician-gynecologists.” We appreciate the helpful comments from the reviewers and editorial staff, and in the accompanying document we have responded to each of the comments.

As the lead author, I affirm 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.

We look forward to hearing from you.

Sincerely,
Daniel Grossman, MD

Response to reviewer comments
Below each reviewer comment we have added our responses in bullets.

REVIEWER COMMENTS:

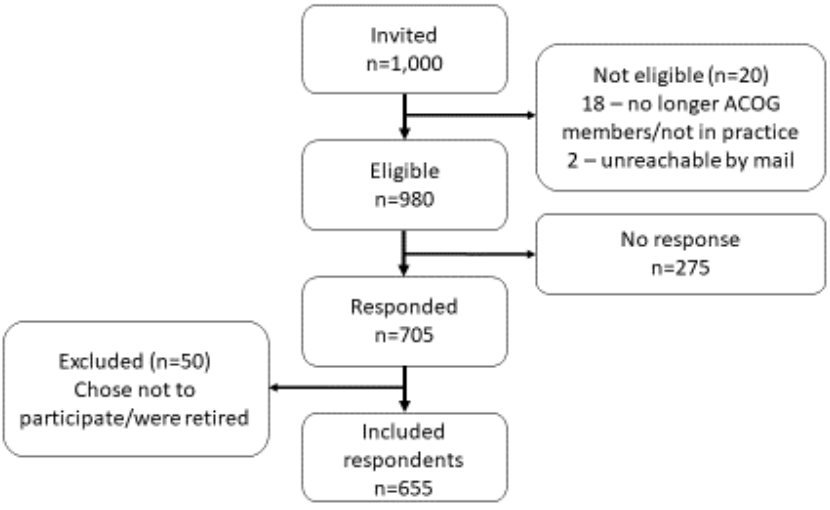
REVIEWER #1:

This is a mailed survey study to report on the proportion of OBGYNs who provide abortion care and to explore barriers to provision of medication induced abortion.

Main issues:

1- Response rate was calculated to be 71% based on receiving 698 responses from 980 sample and of those reported as responders, 43 were excluded for either retiring or because they did not want to participate in the survey. Those who refused to participate should also be labeled as "non-responders" which would reduce the response rate. Please include the actual numbers and include a figure with all the stipulation reported in method section and results

- We have recalculated the response rate as the reviewer suggests: 655 respondents who provided data divided by the eligible sample of 980, which equals 67%. We made this change in lines 39, 177 and 301. Below is a figure showing the numbers. However, we do not think it is necessary to include this in the manuscript since we are no longer differentiating between those who did not respond and those who opted out, but we will defer to the Editors if they believe it would be useful.



2- Identifying the proportion of OBGYNs who provide abortion services is the main objective of this study. So, it is very important to determine the denominator used and how representative that is of the target population which is the US OBGYN physicians. Please include clearly the selection process from the target population to those included in the final analysis for that specific aim.

- The Collaborative Ambulatory Research Network (CARN) has been used in many surveys of ACOG Fellows to assess US ob-gyn practice. The Network has been described in most detail in Leddy et al. 2011, which is reference 5 in our manuscript. As noted in that paper, CARN members are representative of each of the 11 ACOG districts. If the Editors would like us to add more details about CARN members, we can do so, but we have not seen similar details in recent publications in this journal that involved surveys with a CARN sample.
- We have added as a limitation that CARN members may represent a subset of more engaged ACOG Fellows who might be more likely to change their practice if the policy regarding mifepristone dispensing were changed (lines 312-14).

3- Because of the lower response rate to the survey (< 85%) and the nature of this research, non-responders bias is a potential threat to the internal validity of the study. Please compare available date (e.g. demographic, geographic, etc) between responders and non-responders.

- We have information about sex, age and region of residence/practice for non-responders, which we have compared to respondents in the table below. Given the limited data available, we have included a sentence summarizing the findings at line 177-9 rather than including the full table. If the Editors would prefer that we include the table, we can do so.

	Respondents	**Non-Responders**	**p-value**
	%	**%**	
Age			0.26
30-45	25.5	23.2	
46-60	45.3	50.9	
61+	29.2	25.9	
	Mean 53.4, SD 10.6	Mean 53.7, SD ± 9.7	0.66
Gender			
Male	39.0	45.2	0.06
Female	61.0	54.8	
Region			
Northeast	11.4	14.9	0.35
Midwest	26.5	24.2	
South	34.1	31.3	
West	28.1	29.6	

Specific points:

4- Introduction: Well written

5- Methods:

8. Line 80-89: Please move the information about the sampling and numbers to the results.

- We believe the information about the number of participants invited to participate should remain in the methods section. We moved the information about those who were not ACOG members or were unreachable to the results section.

b. What was the method used to improve the response rate?

- As noted in lines 99-104, we sent up to 5 emails with a link to the survey, and then we mailed a paper version of the survey to non-responders. Those who did not respond to the first paper survey were sent a second mailing with a shortened version of the survey.

c. Did the authors use the same method for calculating the proportion of OBGYNS providing abortion services? This is important for the readers to understand if the new reported proportion has changed from the last survey 2008-09.

- Thank you for pointing this out. The prior survey asked the question like this: "Do you provide abortion services? (yes or no)." We specified the time period by asking about provision in the prior 12 months. We have highlighted this difference in the discussion (lines 305-8).

6- Results:

a. Please consider adding another table comparing demographic characteristics between physicians who responded and those who did not respond.

- Please see our response above (point #3).

b. Line 173: The interaction between the gender and geography is very interesting and might need more emphasis in the discussion.

- Our wording here might have been confusing, since we did not specifically explore an interaction between gender and geography. We altered the wording of this paragraph to describe the unadadjusted odds rations and clarified that the geographic findings did not only apply to female ob-gyns.

7- Discussion:

a. Line 273: please provide the generic name and company for Mifeprex

- We added this information to the first mention of Mifeprex (line 124).

8. Please address the low response as a weakness of the study and comment on efforts to increase response and to address non-responder bias.

- We highlighted in the paragraph on limitations that nonresponse bias may have contributed to an overestimate of abortion provision (lines 304-5).

8- Tables and Figures:

8. Please consider adding a figure to report the selection process for participating physicians starting from the total number of OBGYN in the US to the final number included in the analysis for the primary aim which is the proportion of physicians who provide abortion services.

- As we note above in our response (point #2), this level of detail has not been included in other published surveys using members of the Collaborative Ambulatory Research Network. If the Editors would like us to include more information about this Network, we will be happy to do so.

REVIEWER #2:

This is a cross-sectional study describing abortion provision among a national sample of obstetrician-gynecologists who are members of ACOG. This manuscript provides relevant information but manuscript can be edited in length and more focused. Also, use active voice when possible (example, lines 36-38).

- Thank you for this comment. We have edited the manuscript to use active voice more consistently.

Precis

8. Why is "practice setting" highlighted in the précis since it didn't differ between those who did and didn't provide abortions.

- Thank you for highlighting this. We were referring to the urban/suburban/rural differences we observed, which we now refer to as "community type" in the précis and the manuscript.

2. The authors also write that medication abortion provision might increase if physicians could prescribe the medications. While this may be true, table 4 shows other more frequently reported reasons than the actual provision of medical abortion (such as lack of training). Furthermore, the ability to prescribe medications is different from a patient actually being able to obtain the medications at a pharmacy, which we know with emergency contraception. Instead, consider modifying précis to something like: "Abortion provision varies by geography among obstetrician-gynecologists; while multiple barriers to medication abortion exist, the option for physician prescribing may facilitate medication abortion provision."

- We appreciate the reviewer's comments and suggestion for revising the précis. However, we prefer our modified version for several reasons. First, we think it is important to include the proportion of ob-gyns who reported providing abortion. Second, while it is true that there were other factors that limited provision of medication abortion beyond having to stock mifepristone in the clinic, it seems that the ability to write a prescription for the drug would be a motivating factor to overcome some of the other barriers. Only 40 respondents cited the requirement to stock the medication in the clinic as the reason for non-provision, yet 102 reported they would start providing if they could write a prescription for the medication.
- We also agree with the reviewer that there may be other challenges to dispensing mifepristone at pharmacies, including pharmacist refusals. However, there are also potential solutions to these challenges, including provision via mail-order pharmacies. Clearly we cannot address all of these issues in the précis, but we think our statement that "medication abortion might increase" accurately reflects our findings. We added pharmacist refusals as a potential obstacle in line 311.

Introduction

3. Lines 65-66: Clarify statement re: characteristics of OBGYNS more likely to provide abortions. Is it female physicians who live in an urban area or Jewish were more likely to provide?

- We apologize for the confusing wording and have changed "those" to "physicians" to make it clear that each of the following groups were more likely to provide: female physicians, physicians living in urban areas, and Jewish physicians.

4. Lines 75-77: Add the word "abortion" after medication

- This correction has been made.

Methods

5. This section is almost 4 pages of text, which seems long for describing a survey study. Could the authors consider including a copy of the survey as supplemental material and summarize the questions (instead of including the entire question, example 121-124)?

- We defer to the Editors about whether this section needs to be shortened. Some of the other reviewers asked for additional information in this section. Overall, we believe the level of detail in the methods is appropriate and similar to other survey studies published in this journal.

6. Lines 87-89: The lines regarding the 20 who were excluded should be part of the results. Consider putting inclusion/exclusion criteria for the survey participants in this section instead.

- As we note in the response to Reviewer 1, we have moved this information to the results section.
- We modified the first sentence of the results section (lines 80-1) to clarify that we included in the survey ACOG Fellows and Junior Fellows who were currently in practice.

Results

7. This section (3 pages in length) can be shortened since the data are presented in the text and tables.

- We shortened some of the results section, such as the findings from the univariable analysis.

8. The determination of the response rate is confusing. 1000 CARN members were randomly selected. 18 were not ACOG members or no longer in practice; 2 were unreachable by mail leaving 980 potential participants. 698 then responded to the survey, but of those 43 were excluded because they did not want to participate or were retired. How are these 43 different from the18 who were not ACOG members or no longer in practice? Also, why are the authors counting those who do not want to participate in the response rate?

It seems like the response rate should be the total # of usable responses (n=655) over a denominator of all who were sent the survey (n=1000) or all who would have been eligible for the survey (1000 - [those who had retired +/- those unreachable by mail]). Those who chose not to participate should be included among the non-responders.

- As noted in our response to Reviewer 1, we have recalculated the response rate as suggested. The 18 respondents who were excluded because they were not ACOG members or no longer in practice mailed back their surveys and noted this on the returned survey. The 50 respondents shown in the figure at the beginning of this document who were noted to have declined to participate or were retired clicked a link when they were sent the email with a link to the survey. Unfortunately we cannot differentiate among this group those who chose not to participate from those who were retired.

Discussion

9. Comment on whether these 1000 sampled in the CARN are representative of ACOG members (demographics etc).

- As we note in our response to Reviewer 1, CARN members are representative of each of the 11 ACOG districts.

Tables

10. Table 2: In the first row, move the overall "provided any induced abortion" to the top line and indent the subsequent lines.

- We have made this change.

11. Table 3: Why give median and mean. The numbers are very different, likely not normal distribution. Give median and range instead.

- We agree with the reviewer that the numbers are not normally distributed. We removed the mean and added interquartile ranges.

REVIEWER #3:

This is a overall concise well-written manuscript conveying the results of a survey of ACOG fellows and junior fellows. The purpose of the survey was to estimate the proportion who provided induced abortion in the prior year, and identify barriers to provision. The survey design, and analysis are appropriate. The results and tables are cleanly written and concise.

I would recommend the authors expand on the limitations section of the discussion: Provide more detail on how nonparticipation bias could skew the results.

- As noted above, we highlighted in the paragraph on limitations that nonresponse bias may have contributed to an overestimate of abortion provision (lines 301-14).

The sentence on Line 283-286 is wordy and difficult to interpret.

- We tried to clarify the sentence as follows: "The hypothetical question about prescribing mifepristone may overestimate the impact of allowing pharmacy dispensing of the drug, as other barriers, such as practice restrictions and pharmacist refusals, may still limit expansion of medication abortion."

STATISTICAL EDITOR'S COMMENTS:

The overall response rate is good, but for the subsets "Region" or "Practice location", which were correlated with abortion provision, what were the response rates? If there were any selective differences, could those have affected the analysis? Was there a disproportionate distribution of responses to the long survey?

- Please see our response to Reviewer #1, point 3.
- With regard to the long survey, there was no difference by geographic region (see table below). We have added a statement to this effect at line 184-5.

Survey type	Region				
	Northeast	Midwest	South	West	Total
Long	58	137	169	147	511
	85.29	87.26	85.35	88.02	86.61
Short	10	20	29	20	79
	14.71	12.74	14.65	11.98	13.39
Total	68	157	198	167	590
	100.00	100.00	100.00	100.00	100.00

Pearson chi2(3) = 0.7164 Pr = 0.869

Table 1: Should include a column of unadjusted ORs to contrast with aORs. The aOR estimate could be consolidated into one column with its CIs. The p-values are redundant, since CIs are cited. Could indicate with footnote the significant p-values if desired. Should indicated in footnote to table the variables included in the final adjustment model. (apparently just age and gender, but should be explicitly stated)

- These changes have been made. For ease of viewing, we have accepted the changes in Table 1, but please let us know if you would like a version with the changes tracked.

Table 3: Should include measure of variability: SD for means and range or IQR for medians.

- At the suggestion of Reviewer 2, we removed the means, but we added IQR.

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, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

- OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.

2. 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.

- We have included this information in the cover letter.

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

- We are submitting the STROBE checklist with this resubmission.

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 will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at http://links.lww.com/AOG/A515, and the gynecology data definitions are available at http://links.lww.com/AOG/A935.

- We have used the relevant reVITALize definitions. Of note, since we submitted our original manuscript, the term for medication abortion changed from “medication induced abortion” to “medication abortion.” We have made this change throughout our manuscript.

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 appendixes).

Please limit your Introduction to 250 words and your Discussion to 750 words.

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

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

- We believe we have followed all of these guidelines in our acknowledgements.

7. 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.

- The word count for the abstract is 293.

8. 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.

9. 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 edited the manuscript to remove the virgule symbol.

10. 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.

11. The American College of Obstetricians and Gynecologists' (College) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite College documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly. If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if a College

document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All College documents (eg, Committee Opinions and Practice Bulletins) may be found via the Resources and Publications page at http://www.acog.org/Resources-And-Publications.

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Daniel Mosier

From: Grossman, Daniel [redacted]
Sent: Monday, November 26, 2018 2:41 PM
To: Daniel Mosier
Subject: RE: Manuscript Revisions: ONG-18-1708R1

Hi Mr. Mosier,
Thanks for your quick review of our manuscript.

1. The tracked edits look fine.
2. That statement in the Abstract is already in the text at lines 226-9:
    a. When those who did not provide medication abortion but reported having patients seeking abortion were asked if they would offer the service if they could write for the medications on prescription, 28% said they would offer medication abortion, 47% said they would not, and 22% said they were not sure (Table 4).
3. The addition at line 86 is fine.

Thanks again,
Dan

From: Daniel Mosier [mailto:dmosier@greenjournal.org]
Sent: Monday, November 26, 2018 6:10 AM
To: Grossman, Daniel [redacted]
Subject: Manuscript Revisions: ONG-18-1708R1

Dear Dr. Grossman,

Thank you for submitting your revised manuscript. It has been reviewed by the editor, and there are a few issues that must be addressed before we can consider your manuscript further:

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.
2. LINE 57: Please be sure this is stated in the body of your paper. Statements and data that appear in the Abstract must also appear in the body text for consistency.
3. LINE 86: This information was added from your abstract.

Please let me know if you have any questions. Your prompt response to these queries will be appreciated; please respond no later than COB on **Wednesday, November 28th**.

Sincerely,
-Daniel Mosier

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