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 20, 2020
To: "Chiamaka Onwuzurike"
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-841

RE: Manuscript Number ONG-20-841

Examining inequities associated with changes in obstetric and gynecologic care delivery during the COVID-19 pandemic

Dear Dr. Onwuzurike:

Your manuscript has been rapidly reviewed by the Editors. We would like to pursue fast-track publication. If you can address the comments below and submit your revision quickly, the Editorial Office will start working on it as soon as possible. I am setting the due date to April 22, but we will start working on it whenever you can submit.

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).

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 Apr 22, 2020, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #2:
1. Abstract. The abstract summarizes the manuscript well.
Lines 29-31. Here and elsewhere, if the target audience includes those making the changes in care (physician leaders), might call them something other than healthcare systems.

2. Lines 33-40. Starting with a vignette is a nice touch, but I think readers might want to hear a little more. It doesn't have to be something tragic or more compelling, but if you have that, might revise. What happened next? The transportation issue and appointment time problem aren't unique to Covid - what is different now? As physician leaders, what have you done to change the policy at your institution?

3. Lines 53-106. These are all reasonable policies. Might consider making this a table (box). Additional topics to include: masking of all employees and patients; expanding PPE on L&D; calling patients prior to appointments to make sure they don't have symptoms or infected family members.

4. Lines 102-106. Unlike other content in this section, this statement is about risk to healthcare providers in the OR. It seems off topic. If the authors want to include it, they might want to add obstetrical protocols as well.

5. Lines 107-109. Is this about impact of system changes on patients or about COVID-19 prevalence in disadvantaged patients? Lines 110-112 are about prevalence.

6. Lines 116-127. Might streamline or limit the content to Ob/Gyn.

7. Lines 128-138. Would include something about workers not being unable to leave their jobs for in-person or even virtual appointments. Might also include something about those who are no longer able to access employment or social support services.

8. Lines 158-176. Might limit this content. Initial celebrity reports were a while ago. It is not necessary to write out the full name of an author, here or in line 205. I'd suggest omitting rationing ventilators with bias against those who are socioeconomically disadvantaged, because the rest of your commentary isn't about critical care.

9. Lines 200-213. Is there evidence of physician bias against the poor? A Gynecologist will decide upon the urgency of surgery, but most readers probably don't think that their decisions are based on anything other than evidence. Also, without dismissing the topic of abortion, it doesn't usually fall into the category of Gyn surgery.

Reviewer #3: In this commentary, authors explored inequities associated with OBGYN delivery during COVID-19 pandemic. They argued socially vulnerable individuals are disproportionately affected by COVID-19 with worse outcomes and that healthcare and hospital policies may further exacerbate restricted access to quality care and further worsen outcomes.

1. In general, the commentary highlighted structural inequities including disproportionately higher rates of co-morbid conditions that worsen COVID-19 outcomes and although true for the general population, it isn't at all clear that these factors influence outcomes of pregnancy in women or gynecologic outcomes. In other words, specific impact on OBGYN practice is not well highlighted.

2. Certain policies or practice changes that impact delivery of high-quality obstetric care are highlighted including, visitors' policy on access to care, language barrier to effective screening, restricted access to telehealth necessitating physical visits that risk contracting COVID-19, stay at home policy that may increase risk of domestic abuse and mood disorders. Authors appropriately identified these as un-intentional consequences of practice changes.

3. Abstract; lines 25-27: include why outcomes are worse in general.
Lines 27-30: no evidence of poorer OBGYN outcomes was presented and therefore the statement should be softened.

4. Lines 22-115; should be edited for brevity. Policy recount here is familiar to all OBGYNs and need not be elaborate.

5. Lines 124-127; it will be helpful for readers to understand the reasons for screening inequities (lines 139-146), and restricted access to testing in this paragraph.

6. Lines 155-7; isn't this failure of communication?

7. 158-176; several issues here. First, it may be more appropriate to examine principles rather than quoting an individual not recognized as an authority in health disparities from a magazine article.

Second, as a public health policy matter, is it not appropriate that the initial phase of controlling a communicable disease is to contain it? Containment involves actions taken to restrict initial spread of diseases including travel bans. That is inherently discriminatory; so, for example, ban of Liberian/certain African flights and screening individuals based on travel/contact patterns helped contain the spread of Ebola virus. What if vulnerable populations in the US were disproportionately screened for Ebola without the travel history?

What is vague about the initial screening criteria?

Isn't the problem here that we were slow to recognize community spread (person to person without travel) and slow in pivoting to target vulnerable populations (for example, nursing homes residents) for screening?

Lines 172-176; is pure conjecture based on "rationing" of ventilators in Italy. The hottest state in the US (NYC) for CVID-19 has not come even close to capacity of available ventilators and beds.

Lines 177-182; needs to be tempered- according to Pew Research(https://www.pewresearch.org/internet/fact-sheet/mobile/), 96% of Americans own a cell phone of some kind. Prenatal OB visits can be entirely telephone based and if needed asynchronous.

Testing in general has remained inadequate; some at highest risk, including healthcare workers (regardless of gender, race etc) have not had access to testing. That we all read about asymptomatic "celebrities" getting tested is inevitable- we are more likely to hear about them than anyone, yet they represent a tiny fragment of the population. This paragraph needs re-work and appropriate context.

8. Lines 205-213; it is unclear how definitions of non-elective surgeries may disproportionately affect a vulnerable group. If your department allows malignancies and diagnostic tests for malignancies, why then would post-menopausal bleeding or complex adnexal masses (with validated risk stratification) not be included? And whatever is included should be based on diagnosis and equally implemented. Are you suggesting some PMBs may be investigated and others will not?

9. Lines 214-229; overall, authors could offer more specific solutions to the issues they raised, specifically those that OBGYNs- practitioners, hospitals and administrators can directly influence. Some issues are beyond our immediate control- prevalence of chronic disease states, ability to socially distance, or transportation issues, but surely we can address visitor

policy exceptions, ensure consistent access to interpreters, better understanding of and empathy for our patients' social constructs, intensified screening of at risk individuals for domestic abuse or mood disorders and access to support services, modification of telehealth services to suit individuals or setting up satellite clinics in local communities away from complex hospital settings are some examples. Also, let's not forget about the need to enroll pregnant COVID 19 in appropriate ongoing clinical (therapeutic & vaccine) trials; in that sense, all pregnant women are under-represented and vulnerable group.

EDITOR 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. 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).

4. 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.

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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 Apr 22, 2020, we will assume you wish to withdraw the manuscript from further consideration..

Sincerely,

The Editors of Obstetrics & Gynecology

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

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

April 21, 2020

Re: Resubmission of manuscript *Examining inequities associated with changes in obstetric and gynecologic care delivery during the COVID-19 pandemic,* ONG-20-841

The Editors
Obstetrics & Gynecology
409 12th Street, SW
Washington, DC 20024-2188

Dear Editors:

Thank you for considering our manuscript, "Examining inequities associated with changes in obstetric and gynecologic care delivery during the COVID-19 pandemic" for publication and for the opportunity to revise it. We greatly appreciate the comments and suggestions of the reviewers and have made revisions and suggested edits.

Following this letter are the reviewer comments with our responses in italics. Changes to the manuscript text are marked using track changes. The revision has been developed in consultation with all co-authors, and each author has approved the final form of this revision.

Thank you again for your consideration.

Sincerely,

Chiamaka Onwuzurike, MD

Reviewer #2:
1. Abstract. The abstract summarizes the manuscript well.
Lines 29-31. Here and elsewhere, if the target audience includes those making the changes in care (physician leaders), might call them something other than healthcare systems.

We agree that using the term physician leaders is more appropriate given the target audience of this paper. We have replaced the term 'healthcare systems' with 'physician leaders'

2. Lines 33-40. Starting with a vignette is a nice touch, but I think readers might want to hear a little more. It doesn't have to be something tragic or more compelling, but if you have that, might revise. What happened next? The transportation issue and appointment time problem aren't unique to Covid - what is different now? As physician leaders, what have you done to change the policy at your institution?

We have more explicitly linked the solutions suggested in the concluding paragraph back to this example. We agree that issues such as childcare are not unique to COVID-19. What is different now are new policies restricting visitors and new policies limiting transit city-wide. For example, public transit in our city has significantly limited service to a weekend schedule (rather than usual weekday schedule), which can make travel more onerous and challenging. Rather than bringing her child with her to the visit, she is now unable to have anyone accompany her during her clinical appointments. We comment on how we have added pre-visit screening calls to inform patients that they must come alone and to offer suggestions for receiving care if transportation and childcare are barriers. We also suggest in the concluding paragraph that hospitals may consider providing childcare during visits as an additional service for patients in need.

3. Lines 53-106. These are all reasonable policies. Might consider making this a table (box). Additional topics to include: masking of all employees and patients; expanding PPE on L&D; calling patients prior to appointments to make sure they don't have symptoms or infected family members.

We have revised this section to include these policies in Box 1 and edited this section for brevity.

4. Lines 102-106. Unlike other content in this section, this statement is about risk

to healthcare providers in the OR. It seems off topic. If the authors want to include it, they might want to add obstetrical protocols as well.

We agree and have removed this section in the revised manuscript.

5. Lines 107-109. Is this about impact of system changes on patients or about COVID-19 prevalence in disadvantaged patients? Lines 110-112 are about prevalence.

We have revised this paragraph for clarity. Regarding Lines 107-109, this commentary is about impact of system changes on patients, particularly vulnerable populations. We hypothesize that the impact of system changes will disproportionally harm disadvantaged patients if an equity lens is not proactively applied to policy change. We want to bring to the foreground of that conversation the fact that vulnerable populations are already disproportionately impacted by COVID-19; suffering greater rates of infection, morbidity and mortality. Reasons include unequal access to phone service and internet to participate in telehealth visits, essential workers are less able to attend virtual or in-person visits, potential of bias in decisions regarding surgery timing, etc

6. Lines 116-127. Might streamline or limit the content to Ob/Gyn.

We have streamlined this section. We believe it is important to highlight the disparities we may see in COVID-19 incidence and outcomes for OB/GYN patients. The data provided by states highlighting higher rates of infection, morbidity and mortality by race include pregnant women and women we may see in a gynecology practice. It is important for OBGYNs to be aware of which patients are a high risk of infection and poor outcomes as OBGYNs serve an important role in screening and referral for testing for many women. Finally, unpacking why these inequities exist serves to support why we suggest there may also be disparities in obstetric and gynecologic outcomes during the pandemic.

7. Lines 128-138. Would include something about workers not being unable to leave their jobs for in-person or even virtual appointments. Might also include something about those who are no longer able to access employment or social support services.

We agree that it would be important to add a sentence about challenges essential workers face in leaving work for in-person or virtual visits. We have added this through example and into the section on challenges faced by vulnerable groups.

8. Lines 158-176. Might limit this content. Initial celebrity reports were a while ago. It is not necessary to write out the full name of an author, here or in line 205. I'd suggest omitting rationing ventilators with bias against those who are socioeconomically disadvantaged, because the rest of your commentary isn't about critical care.

We have removed the reference to celebrity reports as well as reference to the author of that article by name. We wanted to leave in the discussion regarding allocation of limited medical resources to later link that to the discussion about gynecologic surgery. We have significantly edited this section based on these comments and those of Reviewer#3 to provide more appropriate context to discussions surrounding potential allocation of scarce medical resources.

9. Lines 200-213. Is there evidence of physician bias against the poor? A Gynecologist will decide upon the urgency of surgery, but most readers probably don't think that their decisions are based on anything other than evidence. Also, without dismissing the topic of abortion, it doesn't usually fall into the category of Gyn surgery.

We will cite existing evidence indicating racial disparities in route of hysterectomy with black women more likely to undergo an open hysterectomy compared to minimally invasive hysterectomy even after adjusting for confounding medical and surgical factors (Alexander AL, Strohl AE, Rieder S, Holl J, Barber EL. Examining Disparities in Route of Surgery and Postoperative Complications in Black Race and Hysterectomy. Obstet Gynecol. 2019;133(1):6–12.) One explanation for this could be individual physician level factors including bias. It would not be unreasonable to think this could even extend to whether or not a patient was offered surgery particularly under the circumstances described. We want to highlight the importance of being aware of this as a potential means of introducing bias into gynecologic care during the COVID-19 pandemic. We have revised this paragraph to hopefully make that point clearer.

With regards to abortion, we chose to include abortion as an important example of an OB/GYN procedure about which state-level recommendations were made about urgency which was rather unique. In our department, dilation and curettage or evacuation is considered to be a gynecologic (rather than obstetric) procedure performed by our family planning colleagues which is why we have referred to it as such but acknowledge that it is a pregnancy-related procedure.

Reviewer #3: In this commentary, authors explored inequities associated with

OBGYN delivery during COVID-19 pandemic. They argued socially vulnerable individuals are disproportionately affected by COVID-19 with worse outcomes and that healthcare and hospital policies may further exacerbate restricted access to quality care and further worsen outcomes.

1. In general, the commentary highlighted structural inequities including disproportionately higher rates of co-morbid conditions that worsen COVID-19 outcomes and although true for the general population, it isn't at all clear that these factors influence outcomes of pregnancy in women or gynecologic outcomes. In other words, specific impact on OBGYN practice is not well highlighted.

We have made revisions to underscore how the changes in OB/GYN practice and hospital policy in response to COVID-19 may exacerbate inequities through challenges in accessing obstetric and gynecologic care (visitor restrictions and childcare, telehealth visits, limited GYN surgery) which could potentially impact outcomes.

We write: While changes in obstetric and gynecologic care are being universally applied within hospital systems and obstetrics and gynecology practices, it is critical to recognize that the impact on individual patients will be anything but uniform. Socially vulnerable or disadvantaged groups are disproportionately more likely to contract COVID-19 and have more severe morbidity and mortality from the disease. Preliminary data from major cities across the United States already reflect this trend. That said, structural changes under way in the healthcare system and our larger society in response to the pandemic will simply make it more difficult for socially vulnerable or disadvantaged groups to obtain necessary obstetric and gynecologic care. For example, women in low-wage, service sector jobs deemed essential (e.g. public transit or hospital environmental service) may have unequal access to phone service or internet to participate in virtual care or may be afforded less time to attend a pre-procedure appointment to undergo testing for SARS-CoV-2 prior to a scheduled procedure like cesarean delivery or cancer therapy.

2. Certain policies or practice changes that impact delivery of high-quality obstetric care are highlighted including, visitors' policy on access to care, language barrier to effective screening, restricted access to telehealth necessitating physical visits that risk contracting COVID-19, stay at home policy that may increase risk of domestic abuse and mood disorders. Authors

appropriately identified these as un-intentional consequences of practice changes.
Yes, we agree that these are all well-intentioned and necessary policies that often have unintended consequences that differentially impact patients. We also make suggestions to address the barriers of vulnerable populations in policy creation.

3. Abstract; lines 25-27: include why outcomes are worse in general.
Lines 27-30: no evidence of poorer OBGYN outcomes was presented and therefore the statement should be softened.

Regarding lines 25-27, we have edited the abstract to include some potential explanation for the why COVID-19 outcomes are worse in socially vulnerable populations including limited ability to practice risk-reducing behaviors and existing disparities in prevalence of chronic medical conditions and access to care. Regarding lines 27-30, the statement was softened to say "…may lead to poorer outcomes"

4. Lines 22-115; should be edited for brevity. Policy recount here is familiar to all OBGYNs and need not be elaborated
This has been significantly edited and these have now been included as Box 1 and Box 2. The general hospital-wide policies have been completely removed from the body of the manuscript. We have left some discussion of the OBGYN specific policies as they are referred to later in the manuscript.

5. Lines 124-127; it will be helpful for readers to understand the reasons for screening inequities (lines 139-146), and restricted access to testing in this paragraph.

We agree with the importance of explaining the reasons for restricted access to testing and screening inequities which now explained later in the revised manuscript. Our goal was to spend a paragraph describing each of the points: first the challenges in practicing social distancing and other risk reducing behaviors, second: symptoms screen and communication inequalities that impact the ability to effectively screen for symptoms, and then finally the issue of testing. We believe this is clearer in the revised manuscript.

6. Lines 155-7; isn't this failure of communication?

Yes this is a failure of communication. It is also representative of the lived reality of those who have frequently experienced discrimination or felt disenfranchised by the

medical system. That said, we made revisions to further explain this unintended consequence, how this failure of communication could be avoided and how it is a reality for the disenfranchised to accept that options may not be available to them.

7. 158-176; several issues here. First, it may be more appropriate to examine principles rather than quoting an individual not recognized as an authority in health disparities from a magazine article.

We understand and have removed specific reference to Dr. Blackstone by name in the body of the manuscript as she would not be recognized by name as an authority on the topic. Although there are now many other articles on the topic of racial disparities and COVID-19 in the lay and academic literature, this was the only published article on the topic at the time that we began this writing this manuscript. We still want to reference the specific example of bias in testing criteria that she highlighted in her article. It is an important example of unintended consequences of well-intentioned criteria and how those can disproportionally impact a vulnerable population and we believe this is important part of a conversation around health equity. We have restructured this section to reflect this as well as the reviewer's comments below.

Second, as a public health policy matter, is it not appropriate that the initial phase of controlling a communicable disease is to contain it? Containment involves actions taken to restrict initial spread of diseases including travel bans. That is inherently discriminatory; so, for example, ban of Liberian/certain African flights and screening individuals based on travel/contact patterns helped contain the spread of Ebola virus. What if vulnerable populations in the US were disproportionately screened for Ebola without the travel history?

Thank you for this comment. Containment is absolutely appropriate. We do not mean to suggest that it is not an appropriate or effective strategy. We also do not mean to suggest that the attempts to identify a high-risk population for testing was inappropriate or incorrect. Rather, we believe there is value in the awareness that is gained by retrospectively looking at what happened and how it may have disproportionately impacted certain communities and exacerbated existing inequities. We try to make this point again in the concluding paragraph. Some of the issues we have raised are within the immediate control of readers, and for those issues, we hope to inspire action. Some of the issues raised are not within the immediate control of readers, and for those issues (e.g. testing criteria), awareness and understanding of the impact and the affected communities is the goal. In

response to the above comment and others, we have edited this section to clarify these points and provide examples of applying an equity lens.

What is vague about the initial screening criteria?

Criteria were not vague and this comment has been removed from the revised manuscript.

Isn't the problem here that we were slow to recognize community spread (person to person without travel) and slow in pivoting to target vulnerable populations (for example, nursing homes residents) for screening?

Yes, we agree that we were slow to recognize community spread but would take this a step further to argue that this delay in recognition of community spread potentially disproportionately impacted poor communities. For example, in the context of extensive community spread, a wealthier individual is more likely to have a close contact of theirs be tested, (e.g. due to history of recent travel), diagnosed, and appropriately isolated and thus limiting spread within their social networks, likely of similar SES.

Lines 172-176; is pure conjecture based on "rationing" of ventilators in Italy. The hottest state in the US (NYC) for CVID-19 has not come even close to capacity of available ventilators and beds.

We acknowledge that this is a hypothetical situation that has thankfully not been a reality in the United States, even in New York City. However, during this pandemic, hospital systems across the country have had to develop crisis standards of care to guide medical decision-making in the event that such circumstances arise, including criteria for allocation of scarce medical resources. We have edited this section to provide this important context.

Lines 177-182; needs to be tempered- according to Pew Research(https://www.pewresearch.org/internet/fact-sheet/mobile/), 96% of Americans own a cell phone of some kind. Prenatal OB visits can be entirely telephone based and if needed asynchronous.

Thank you for this comment. While it is true that cell phone ownership in the United States is very high, there are still significant racial and socioeconomic differences in having consistent cell service. According to Pew Research, 17% of white Americans surveyed reported having to cancel or cut off service vs 42% of black Americans and 36% of Hispanic Americans. Similarly 10% with household income over

$75,000 vs 44% of those with household income less than $30,000. (https://www.pewresearch.org/internet/2015/04/01/chapter-one-a-portrait-of-smartphone-ownership/#cancel-phone). *Anecdotally and consistent with this data, we have experienced difficulty reaching patients by phone, not because they do not own a phone, but because they don't currently have active service to their phone. We have edited this section to make this important clarification.*

Testing in general has remained inadequate; some at highest risk, including healthcare workers (regardless of gender, race etc) have not had access to testing. That we all read about asymptomatic "celebrities" getting tested is inevitable- we are more likely to hear about them than anyone, yet they represent a tiny fragment of the population. This paragraph needs re-work and appropriate context.

We acknowledge that testing in the United States has been completely inadequate and thus has impacted many different communities and groups including healthcare workers. We do not mean to imply that racial minorities or those of lower socioeconomic status were uniquely affected by the testing problems but only to highlight the ways in which they were. We have made edits to clearly acknowledge that while also highlighting the impact the shortage of tests on these particular already vulnerable populations. We removed the reference to testing of celebrities.

8. Lines 205-213; it is unclear how definitions of non-elective surgeries may disproportionately affect a vulnerable group. If your department allows malignancies and diagnostic tests for malignancies, why then would post-menopausal bleeding or complex adnexal masses (with validated risk stratification) not be included? And whatever is included should be based on diagnosis and equally implemented. Are you suggesting some PMBs may be investigated and others will not?

It is true that our department has offered some guidance to help physicians make appropriate decisions about the urgency of a given procedure, however, these are not strict criteria and decisions are ultimately left to the discretion of the individual provider. We would argue strongly that allowing for this level of discretion is not necessarily wrong but does carry the potential to introduce bias as is the case when any decision is made without the use of specific objective criteria that are to be applied universally. There is existing evidence that there are racial disparities in route of hysterectomy with black women more likely to undergo an open

hysterectomy compared to minimally invasive hysterectomy even after adjusting for confounding medical and surgical factors (Alexander AL, Strohl AE, Rieder S, Holl J, Barber EL. Examining Disparities in Route of Surgery and Postoperative Complications in Black Race and Hysterectomy. Obstet Gynecol. 2019;133(1):6–12.) One explanation for this could be individual physician level factors including bias. It would not be unreasonable to think this could even extend to whether or not a patient was offered surgery particularly under the circumstances described. We want to highlight the importance of being aware of this as a potential means of introducing bias into gynecologic care during the COVID-19 pandemic. We have revised this paragraph to hopefully make that point clearer.

9. Lines 214-229; overall, authors could offer more specific solutions to the issues they raised, specifically those that OBGYNs- practitioners, hospitals and administrators can directly influence. Some issues are beyond our immediate control- prevalence of chronic disease states, ability to socially distance, or transportation issues, but surely we can address visitor policy exceptions, ensure consistent access to interpreters, better understanding of and empathy for our patients' social constructs, intensified screening of at risk individuals for domestic abuse or mood disorders and access to support services, modification of telehealth services to suit individuals or setting up satellite clinics in local communities away from complex hospital settings are some examples. Also, let's not forget about the need to enroll pregnant COVID 19 in appropriate ongoing clinical (therapeutic & vaccine) trials; in that sense, all pregnant women are under-represented and vulnerable group.

We agree that there are many different types of issues and challenges that we have raised in our manuscript, and some are more easily addressed than others. One of our goals in writing this was to encourage and empower physician leaders to consider these issues when creating and implementing new policies whether in an individual patient encounter, in a physician practice, or within a large hospital or healthcare system. In writing this, we had in mind that the readership of this journal includes physician leaders with varying scopes of influence that, in some cases, extend beyond an individual practice. In this concluding paragraph, our goal was to provide a framework for thinking through these issues in one's own practice or community. As mentioned by the reviewer, there are issues that seem beyond an individual's immediate control, and for those we underscore the importance of awareness and acknowledgement of those disparities. We suggest that it is equally important to take the next step to identify barriers and propose "practical and feasible solutions." We agree that it may be helpful to include more specific examples of practical solutions and have edited the manuscript to include those.