CONCLUSION: In ovulatory women conceiving via FET, transfer in the programmed cycles, where a corpus luteum is not present, was associated with higher odds of HDP than transfer in the natural FET cycles. Prioritizing the use of natural FET cycles may represent an opportunity for risk reduction for ovulatory women undergoing FET cycles who would otherwise be counseled toward programmed FET. ∎

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Racial-ethnic diversity of obstetrics and gynecology faculty at medical schools in the United States

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OBJECTIVE: The nation's population is diversifying at a faster pace. Recruiting practitioners who better represent the patient population has become a public health strategy.[1] Furthermore, racial-ethnic diversity of medical school faculty has been linked to medical student diversity, cultural and structural competencies of graduates, and cultural climate of healthcare and research that contribute to institutional excellence.[2] This study aimed to report the racial-ethnic diversity of obstetrics and gynecology faculty at US medical schools concerning the US adult female population.

STUDY DESIGN: This cross-sectional, observational study included individuals who self-reported to belong to any one of the following racial-ethnic groups: Hispanic (of any race), non-Hispanic White, Black or African American, Asian, Native American (American Indian, Alaska Native, Native Hawaiian, or Pacific Islander), or others or unknown. As defined by the Association of American Medical Colleges (AAMC), the underrepresented minority (URM) in medicine is any racial or ethnic population that is underrepresented in the medical profession relative to the numbers of the general population (eg, Black, Hispanic,

and Native Americans). The most recent nationwide data were gathered about full-time obstetrics and gynecology faculty from the 2021 AAMC Faculty Roster, obstetrics and gynecology residents from the 2021 Accreditation Council for Graduate Medical Education Data Resource Book, and US adult females (aged ≥15 years) from the 2019 American Community Survey.[3–5] Female and male faculty were subdivided into junior (instructor or assistant professor) and senior (associate professor or professor) levels. We used the t test to measure group differences. A P value of <.05 was considered statistically significant.

RESULTS: Females constituted two-thirds (4487 [66.6%]) of the 6738 faculty and were more likely to be junior faculty than senior faculty (75.6% vs 50.5%; $P<.001$). The percentages of the junior and senior faculty in each major racial-ethnic group were compared with the US adult female population in the Figure. Junior faculty were less likely to be White than senior faculty (62.9% vs 72.9%; $P<.001$) and the same as the US female population (62.3%). Junior faculty were more likely to be Black or Hispanic than senior faculty, although these proportions

FIGURE
Racial-ethnic diversity between the US population and ob-gyn faculty
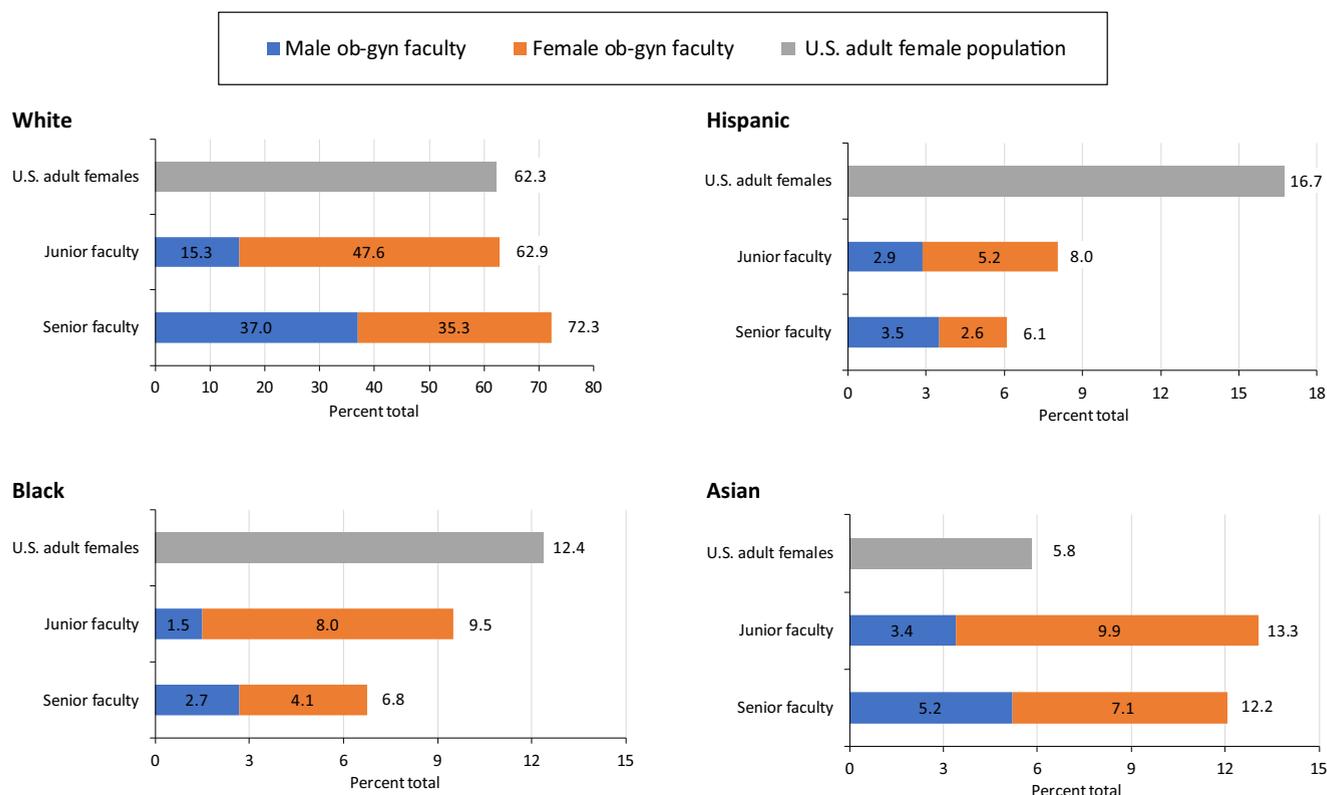
Rayburn. Racial-ethnic diversity of ob-gyn faculty. Am J Obstet Gynecol 2022.

were lower than the adult female population (Black: 8.5% vs 12.4%; *P*<.001; Hispanic: 7.4% vs 16.7%; *P*<.001). Native Americans constituted <1% of all population groups. Asian faculty were more common than US adult female faculty (12.9% vs 5.8%; *P*<.001). The distribution of racial-ethnic groups was not different between faculty and residents who were Asian (12.9% vs 11.9%), Black (8.5% vs 8.3%), Hispanic (7.3% vs 7.2%), or Native American (0.4% vs 0.5%). Those who reported as "others or unknown" were less common among faculty than residents (4.1% vs 15.9%; *P*<.001).

CONCLUSION: Previously, we reported on how the expansion of faculty in the field of obstetrics and gynecology throughout 40 years (from 1973 to 2012) led to greater diversity (more females and underrepresented minorities) than other core clinical departments.[6] Our research letter has provided continuing information about faculty diversity by examining racial-ethnic differences between junior and senior faculty concerning the general female population. We found that the percentages of female faculty and all non-White groups increased since our previous report. This change was likely because of the greater racial-ethnic diversity of the expanding number of faculty, especially

junior faculty who were predominantly female. We wish to explore the hypothesis that continued change in the racial-ethnic diversity of faculty will only occur once more URM students, especially the growing number of Hispanics, are admitted into medical schools and recruited for residency positions. ∎

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Impact of the COVID-19 pandemic on the incidence of prematurity: critical role of gestational age and environment

OBJECTIVE: Data on the incidence of prematurity during the COVID-19 pandemic are contradictory, with some reports showing decreased preterm births and others showing no effect.[1,2] We propose that multiple biologic effects of SARS-CoV-2 infection and environmental changes during the pandemic exert competing effects on the preterm birth rate.

SARS-CoV-2 infection may increase preterm births by increasing preeclampsia and medically indicated preterm births,[3] but its effects on spontaneous preterm births are unknown. Infection is the most commonly identified etiologic contributor to spontaneous preterm births at <28 weeks' gestation.[4] Our preliminary data demonstrated that SARS-CoV-2 placental infection increases the expression of placenta-specific microRNA 519c, which protects against infection-induced preterm birth.[5] Furthermore, environmental effects of the COVID-19 pandemic (lockdowns, quarantine, decreased travel) may decrease pathogen exposures that can trigger infection-

induced preterm birth.[6] Therefore, the effects of the COVID-19 pandemic on the rates of prematurity likely reflect a balance between increased preeclampsia-induced preterm births and decreased infection-induced spontaneous preterm births.

New York was the first epicenter of the COVID-19 pandemic in the United States. The prevalence of SARS-CoV-2 infection exploded in March 2020, with a surge in the urban center. Lockdowns were initiated in all jurisdictions by mid-March. We compared the incidence of extreme prematurity (with and without preeclampsia) in 2020 with that of 2019 in a large cross-sectional study of hospitals in the New York City area.

STUDY DESIGN: Data were collected from urban medical centers (New York University Tisch Hospital, Lenox Hill Hospital, Montefiore Medical Center, Mount Sinai Hospital) and suburban medical centers (New York University Langone Hospital—Long Island, Long Island Jewish Medical Center,

TABLE 1
Number and rates of preterm deliveries in 2019 and 2020

Variables	2019		2020		Difference (95% CI)	P value
	N	Rate/1000	N	Rate/1000		
Deliveries	63,327	—	62,020	—	−1307	.0002
Delivery <35 wk	2255	35.6	2153	34.7	−0.9 (−1.9 to 0.1)	.08
Delivery 28−35 wk	1900	30.0	1864	30.1	0.1 (−0.9 to 1.0)	.9
Delivery <28 wk	355	5.6	289	4.7	−0.9 (−1.3 to −0.6)	<.0001
With preeclampsia	44	123.9	52	179.9	56.0 (28.0−83.0)	<.0008
COVID-19 positive	—	—	1870	30.15	—	—

CI, confidence interval.

Weinberger. Impact of the COVID-19 pandemic on the incidence of prematurity. Am J Obstet Gynecol 2022.