

et al. refer to costs associated with the subcutaneous ICD. However, a thorough cost-efficacy analysis should compare both the costs of the implant itself and implantation of the device and the costs of device-related complications and hospitalizations. For example, our trial showed 50% fewer device infections in the subcutaneous ICD group than in the transvenous ICD group. Treatment for a patient with an infected ICD costs more than £20,000 (approximately \$27,500 in U.S. dollars) in the United Kingdom and more than \$40,000 in the United States.<sup>3</sup>

The PRAETORIAN trial investigated the difference in safety outcomes between the transvenous ICD and the subcutaneous ICD, since efficacy was established in previous trials.<sup>4</sup> Noninferiority and superiority analyses for the primary end point were scheduled and performed. Kim et al. correctly point out that inappropriate shocks and complications have diverging trends. However, we did not anticipate this divergence in our design.<sup>5</sup> The PRAETORIAN-XL trial, a substudy of the PRAETORIAN trial, is under way to assess these outcomes separately in the prolonged follow-up period (an additional 4 years).

We agree with Sato and Nojiri that a large percentage of the subcutaneous ICDs in the

PRAETORIAN trial were first-generation devices, which have a higher incidence of inappropriate shocks than later-generation devices. Follow-up is under way to investigate end points with newer algorithms and later-generation devices.

Reinoud E. Knops, M.D., Ph.D.

Willeke van der Stuijt, M.D.

Lonneke Smeding, Ph.D.

Amsterdam University Medical Centers  
Amsterdam, the Netherlands  
r.e.knops@amsterdamumc.nl

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## Women Physicians and Promotion in Academic Medicine

**TO THE EDITOR:** The article by Richter et al. (Nov. 26 issue)<sup>1</sup> highlights the persistence of gender inequity and confirms the lack of advancement of women in academic medical leadership.<sup>2,3</sup> Equity in health leadership is both a fundamental social justice issue and a population health issue.<sup>4,5</sup> We propose that the time has come to move beyond describing the problems. It is time for effective large-scale change to move the dial on this issue. Building the evidence base on best practices to support gender equity is vital in order to achieve effective, long-term, sustainable career advancement for women in health, including those in academic medicine.<sup>4,5</sup> Women cannot simply be expected to be more like their male colleagues to succeed. There is also a recognized need to move away from individual women having to battle entrenched barriers to career advancement, toward policy-, systems-, and organization-level approaches; this shift would enhance

the ability and motivation of women to advance in their careers and provide opportunities for them to do so.<sup>2,3</sup>

We are currently leading a competitive Australian initiative funded by the National Health and Medical Research Council for the advancement of women in health leadership. This initiative engages health services, professional colleges, and government. Through collaborative implementation research, we aim to strengthen evidence on effective organizational change and to translate this new knowledge into strategies, policies, and practice in order to address gender inequity in health care leadership.

Mariam Mousa, B.H.Sc.

Monash Centre for Health Research and Implementation  
Melbourne, VIC, Australia

Jacqueline A. Boyle, M.D., Ph.D.

Monash Health  
Melbourne, VIC, Australia

Helena J. Teede, M.D., Ph.D.

Monash Partners  
Melbourne, VIC, Australia  
helena.teede@monash.edu

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**TO THE EDITOR:** The study by Richter et al. definitively shows that the gender gap in promotions in academic medicine cannot be explained by a lack of women in the pipeline. This study is one of the largest and most current bodies of evidence highlighting ongoing disparities in academic promotion between female physician faculty members and their male counterparts. Unfortunately, new challenges triggered by the Covid-19 pandemic probably have exacerbated existing trends; submissions of academic papers by female faculty members have decreased, while those of male faculty members have remained relatively unchanged.<sup>1</sup> This divergence is of particular concern, given that published articles are a major criterion on which promotion is based.<sup>1,2</sup>

The study by Richter et al. adds to a growing collection of data documenting ongoing disparities, even after controlling for factors such as age, specialty, number of hours worked, and practice characteristics.<sup>2</sup> The Association of American Medical Colleges, the American College of Physicians (ACP), and others have developed recommendations to address discrepancies.<sup>2-4</sup> It is vital that leaders of academic medical centers and funding agencies implement proposed strategies to address persistent inequities.

Jen Hartmark-Hill, M.D.

Taben Hale, Ph.D.

Amelia Gallitano, M.D., Ph.D.

University of Arizona College of Medicine—Phoenix  
Phoenix, AZ  
jhartmarkhill@email.arizona.edu

No potential conflict of interest relevant to this letter was reported.

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**THE AUTHORS REPLY:** In their letter regarding our article about ongoing inequities in the advancement of women in academic medicine, Mousa et al. highlight the need for top-down systemic and institutional approaches to address this concern rather than bottom-up approaches that rely on the efforts of women to enact change and advance their own careers. We and our coauthors very much agree. The ACP recently recommended solutions for medical schools, including transparency in compensation, explicit family-friendly policies for paid leave, implicit-bias training, and the inclusion of women in hiring committees for leadership positions.<sup>1</sup> The Research Partnership on Women in Science Careers suggested similar institutional policies as well as national policies such as having funders and accrediting bodies set gender-equity criteria for the receipt of funding and awards, providing guidelines for compensation and start-up packages, and publishing lists of institutions that have initiatives to promote gender equity and diversity.<sup>2</sup> In addition, through a critical and thorough review of editorial practices, high-impact journals have aimed to promote a mainstream vision of the leadership of women in medicine and science while recognizing linkages among gender biases, equality, and health.<sup>3</sup>

We also agree with Hartmark-Hill et al. that Covid-19 may exacerbate the gap in advancement. The documented imbalance between men and women in caregiving for children and household tasks, in association with Covid-induced disruptions, could disproportionately diminish women's work productivity in many ways, including their ability to contribute to scholarly publications. This gap could produce a substantial cohort effect, especially for women with younger children. The National Academies of Sciences, Engineering, and Medicine undertook a fast-track study on the effect of Covid-19 on the careers of women in science, technology, engineering, mathematics, and medicine.<sup>4</sup>

To address both long-standing barriers and recent threats to the advancement of women, persons in academic medicine who have power and social capital must fundamentally adopt an inclusive leadership style. Beyond promoting dialogue, policies, and best practices, leaders must listen, reflect, and act with courage to recognize when current notions of meritocracy are misleading. Moreover, they must not only recommend systemic change but also, and more importantly, create accountability to make it happen.

Kimber P. Richter, Ph.D., M.P.H.

Christie A. Befort, Ph.D.

Robert D. Simari, M.D.

University of Kansas Medical Center  
Kansas City, KS  
krichter@kumc.edu

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## The Covid-19 Vaccine-Development Multiverse

**TO THE EDITOR:** We are writing in response to the editorial by Heaton (Nov. 12 issue)<sup>1</sup> on Covid-19 vaccines. Currently, Blacks, Native Americans, and Hispanic or Latino persons are disproportionately affected by Covid-19,<sup>2</sup> and testing to detect SARS-CoV-2 is lagging in low-income and minority neighborhoods.<sup>3</sup> New approaches will be

needed to safely and equitably distribute Covid-19 vaccines.

Drive-through SARS-CoV-2 testing sites in Los Angeles County are widely used by persons from racial and ethnic groups that are representative of that county (Table 1). A pilot influenza vaccination program was conducted at one SARS-

**Table 1. Demographic Characteristics of Persons Who Were Tested for SARS-CoV-2 at Multiple Drive-through Testing Sites and of Those Vaccinated against Influenza at One Drive-through Testing Site in Los Angeles County in 2020.**

Variable	Persons Who Were Tested or Vaccinated
<b>Testing for SARS-CoV-2 from June 26–Oct. 14 at multiple sites</b>	
Race or ethnic group — no./total no. (%)*	
Hispanic or Latino	295,063/686,191 (43)
White	164,686/686,191 (24)
Black	178,409/686,191 (26)
Asian or other	48,033/686,191 (7)
<b>Vaccinations against influenza from Oct. 6–Nov. 5 at one site</b>	
Age — yr	
Median	38
Range	1–86
Race or ethnic group — no./total no. (%)*	
Hispanic or Latino	430/661 (65)
White	126/661 (19)
Black	13/661 (2)
Asian or other	92/661 (14)

\* Race or ethnic group was reported by the participants on a survey.