integration of formal or informal time-variable considerations into the promotion and tenure processes. If so, what forms do these considerations take, and how do they vary across institutions? Understanding the range and nature of these policies could provide valuable insights for institutions contemplating the adoption of CBTV principles in faculty advancement processes.

The potential for CBTV principles to enhance the promotion and tenure system represents a frontier in academic medicine worth exploring. It promises not only to align faculty development more closely with contemporary pedagogical practices but also to foster a more dynamic and meritocratic academic environment. I eagerly anticipate further discussion on this topic and look forward to the authors' insights on the questions raised.

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In Reply to Jones: We thank Jones for his insightful comments on our article and for raising the intersections between competency-based, time-variable (CBTV) education and faculty evaluation and promotion. Jones poses the question: "To what extent are current policies accommodating the concept of time variability in faculty advancement?"

We address this question in several ways. First, even the most rigid and traditional system of tenure and promotion in U.S. higher education offers a modicum of time variability in that faculty members can usually go up for promotion and tenure *early*—they do not have to wait for the end of the probationary period if their academic credentials warrant an early review. Second, as Supplemental Digital Appendix 6 in our article indicates (http://links.lww.com/ACADMED/B545), many medical schools have extended the probationary period beyond the traditional 7-year length. Third, as we discussed in the article, some medical schools have established undeclared appointment tracks that are intended to give faculty additional time to establish their academic credentials before the tenure clock begins. Fourth, the traditional time strictures associated with an up-and-out tenure model apply to fewer and fewer full-time faculty at U.S. medical schools, as Supplemental Digital Appendix 4 indicates (http://links.lww.com/ACADMED/B545). Only 10% of full-time, MD faculty new hires were appointed to a tenure track in 2021. Faculty on non–tenure-track appointments do not typically have the same strict time limits for promotion in rank.

Taken together, these data suggest current policies do accommodate time variability in faculty advancement to some degree. And while time variability in faculty advancement is often considered a strength for U.S. medical schools—allowing for the complexity of faculty careers and the difficulty in establishing research and clinical practices—it is worth raising a cautionary question: Might the lack of time constraints have unintended consequences? Association of American Medical Colleges data indicate that first-time assistant professors at U.S. medical schools have a higher 10-year *attrition* rate (42% for the 2012–2023 cohort of MD clinical faculty) than *promotion* rate (33% for the 2012–2023 cohort of MD clinical faculty).[1] Seeing that, after 10 years from initial appointment, more faculty leave their institutions than are promoted within their institutions is a worrisome indicator for career sustainability.

We agree with Jones that there is more to explore with the alignment between contemporary CBTV pedagogical practices and faculty career development and advancement. With increasing percentages of full-time U.S. medical faculty on nontenure career tracks, how can our sector continue to ensure that faculty careers are meaningful, attractive, and sustainable in a changing pedagogical and practice environment? We look forward to continued conversations on this topic.

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Rethinking the "I" in Diversity, Equity, and Inclusion Efforts Within Academic Medicine

To the Editor: The October 7, 2023 attacks on Israel by Hamas, an organization recognized by the U.S. government as a terrorist group,[1] were a turning point for Jewish people like me and for many other faculty of all faiths in academic medicine. The ensuing months have revealed how ill-prepared we were in academia to address the tremendous polarization and suffering of Jews and Palestinians,[2] and the rising tide of antisemitism.[3] After 18 years as senior associate dean for student affairs and interim co-vice dean for education during the COVID-19 pandemic, and a

long-standing supporter of Diversity, Equity, and Inclusion (DEI), I bore witness to how DEI had so suddenly failed my own community. For the U.S. as a whole, the murder of George Floyd served as a turning point. The events of October 7, 2023 have also heralded a new era that demands a new approach within our medical schools.

Statements made at the March 7, 2024 Congressional hearing by the Higher Education and Workforce Development Subcommittee of the Committee on Education and the Workforce were quite strident. For example, some labeled DEI a "cancer" and considered it "demeaning and racist." One witness stated DEI is dangerous and most dangerous in medical school. Few in Congress spoke in support of DEI. A handful suggested it should include antisemitism.[4] The criticisms leveled at DEI during these hearings make it clear DEI is in peril. Without explicitly expanding its aims, it will not meet its laudable goals, especially in our medical schools.

We must address this failing of DEI to ensure that our aspirations for it will not stall. The surge of antisemitic rhetoric and incidents at protests and encampments within our U.S. universities, especially since October 7, 2023, show that medical schools need to recognize Jewish students and health care professionals as a threatened and marginalized group. The resulting polarization has eroded our ability to see each other in our humanity.

The "I" for inclusion in DEI should offer a larger tent that includes Jews and Israelis, as well as Muslims, Palestinians, and others marginalized and facing discrimination. DEI efforts at medical schools have not overtly addressed racism and discrimination against these vulnerable groups. DEI efforts should be continually refined, and conflicts in prioritizing the needs of different minority groups should be anticipated, not feared. If we are truly aiming for consistency and fairness, DEI efforts within academic medicine should also address antisemitism and provide a pathway for all medical trainees and health care professionals to become informed about it and its history.

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