ssionalism

rriculum Alignment and Evaluation

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ument maps Session 5 learning objectives to teaching, practice, and assessment. It also provides an evaluation plan across Ki –4, a session survey, and an annotated reading list.

culum Alignment Matrix

slide numbers refer to the Session 5 deck (23 slides). MCQ numbers refer to the revised question set. Reading the matrix: ever e is taught (lecture), practiced (PBL and/or activity), and assessed at Kirkpatrick Level 2 or higher. Objective 3's primary assess ely behavioral (the role-play checklist) rather than the MCQ alone — the objective's verb is 'demonstrate.'

e (abbreviated)	Bloom's level	Lecture (slides)	PBL (questions)	Active learning	MCQ #	Evaluation
ship of clinical decisions; ol, not a team member	Understand/Apply	4, 6–7, 17–22	Q2, Q4	—	1	L2: MCQ pre/post. L3: clerksh observation card (shared with Session 4).
adaptive expertise from offloading	Apply/Analyze	8–10	Q4	Part A (commitments may address)	4	L2: MCQ pre/post. L3: student audit.
-centered focus and e in real time	Apply/Create	11–13, 19–22	Q1, Q3	Part B role-play	3	L2: role-play checklist (0–8). L OSCE disclosure station (shar Session 4).
mic and professional n AI use	Apply/Evaluate / Create	14–15, 19–22	Q2, Q4	Part A reflective writing	2	L2: commitment checklist (0–4
AI outputs; raise concerns titutional workflows	Apply/Evaluate	16–22	Q3, Q5	Part B (background-CDS question)	5	L2: MCQ pre/post. L3: observa card. L4: documentation-safet signal.

ation Plan — Kirkpatrick Levels 1–4

and 4 reuse the consortium instruments defined in the Session 4 evaluation plan (OSCE disclosure station, clerkship direct-ion card, documentation-safety and patient-experience signals) rather than duplicating them; Session 5 adds its own Level 2 nts and one Level 4 signal. Feasibility tiers allow all eleven consortium schools to implement at least the core plan.

— Reaction

ession survey (below), about five minutes: perceived ability on each objective, value of the two activities, pacing.

2 — Learning

e/post

MCQs, administered before the session (or asynchronously as pre-work) and after. Paired scores give an objective learning m ctive.

ommitment checklist (0–4)

y the student's partner during the feedback round (or self-scored where the opt-out alternative is used) — one point each: (1) n behavior; (2) names the first situation in which it will be tested; (3) is disclosure-ready (could be read verbatim to a course direc e within one month. The checklist is formative; scores are not collected centrally, preserving the activity's privacy safeguard.

ole-play checklist (0–8)

ed by the observing partner or facilitator — one point each: (1) discloses the recording in plain language early in the visit; (2) se nt rather than announcing; (3) answers the patient's questions honestly, including about background CDS; (4) distinguishes ins itutional disclosure rather than reciting all tools; (5) honors a decline gracefully; (6) adjusts the documentation plan after a decli isparages nor oversells the technology; (8) returns to the patient's agenda promptly.

3 — Behavior

consortium instruments (defined in the Session 4 plan): the OSCE disclosure station at 3–6 months, and the clerkship direct-ion card ('verifies AI-generated content before signing; discloses AI documentation tools when material; explains an AI-informe endation in their own reasoning — and owns the decision'). Session 5 addition to the student self-audit: at clerkship midpoint, s eal encounter in which they either corrected an AI draft against their own record of the visit or named a knowledge gap to a su sentences: what they noticed, what they said, what happened.

4 — Results

signals (Session 4 plan): documentation-safety (AI-draft errors caught before vs. after signature) and patient-experience items.
n — academic-integrity signal: where schools adopt AI-disclosure statements on written work, track the proportion of submissio
a substantive disclosure, measured annually; trend, not baseline, is the metric.

ion caveat

outcomes are influenced by far more than one preclinical session. These indicators are monitored as consortium-level context,
as session effects; the consortium evaluation working group owns this layer.

on Evaluation Survey

ems (1–5, strongly disagree to strongly agree)

this session, I can explain the difference between professionalism and professional identity, and name the elements of profess
ity this session builds on.
describe which kinds of cognitive offloading are desirable and which put my developing clinical reasoning at risk.
e practiced the actual words of disclosing an AI tool to a patient, including responding to a decline.
explain which AI disclosures are an individual clinician's in-the-moment responsibility and which are institutional, systems-leve
onsibilities.
describe what I owe the signing clinician when I edit an AI-drafted note, and what to do when a draft omits something the patie
articulate a specific personal commitment about AI use in my coursework.
reflective writing was a valuable use of class time.
role-play was a valuable use of class time.

nce self-assessment (retrospective pre/post)

osing AI use to a patient in plain language in the first minutes of a visit.
ng a concern respectfully with a more senior clinician about an AI workflow.
ng honestly, to a supervisor, a gap in my own knowledge.

nded

t was the single most valuable thing you learned in this session?
t is one thing about this session that could be improved before it is taught again?

ed Reading List (verified)

owing readings support the session. Distinguish empirical findings from conceptual frameworks, and check current local poli
guidance.

ional identity formation (core)

ss RL, Cruess SR, Boudreau JD, Snell L, Steinert Y. Reframing medical education to support professional identity formation. A
2014;89(11):1446–1451. — The professionalism-vs-identity distinction the definitions rests on.

ss RL, Cruess SR, Boudreau JD, Snell L, Steinert Y. A schematic representation of the professional identity formation and soc
edical students and residents. Acad Med. 2015;90(6):718–725. — The identity-formation model behind the session's framing.

on R. Narrative medicine: a model for empathy, reflection, profession, and trust. JAMA. 2001;286(15):1897–1902. — Listening
nt's story as a clinical skill; the identity element the PBL case turns on.

tgomery K. How Doctors Think: Clinical Judgment and the Practice of Medicine. Oxford University Press; 2006. — Clinical jud
terpretive reasoning that must be the clinician's own; pairs with Schön DA, The Reflective Practitioner (Basic Books; 1983), for
ctive-practice frame in the case's knowledge-gap moment.

ve offloading and adaptive expertise

poulos M, Regehr G. Cognitive metaphors of expertise and knowledge: prospects and limitations for medical education. Med
;41(12):1159–1165. — The adaptive-expertise construct Objective 2 protects. Technically demanding; consider a reading guid

o EF, Gilbert SJ. Cognitive offloading. Trends Cogn Sci. 2016;20(9):676–688. — Offloading as normal cognition — the eviden
e distinction between routine tasks and reasoning practice.

zyń K, Romańczyk M, Kitala D, et al. Endoscopist deskilling risk after exposure to artificial intelligence in colonoscopy: a mult
rvational study. Lancet Gastroenterol Hepatol. 2025;10:896–903. doi:10.1016/S2468-1253(25)00133-5. — Lower unassisted a
ction was observed after AI exposure; the observational design does not establish that AI caused the decline or that this genera
nostic reasoning.

E, et al. Large language model influence on diagnostic reasoning: a randomized clinical trial. JAMA Netw Open. 2024;7(10):e2
ol access is not a substitute for reasoning; cross-referenced from Session 2.

, consent, and disclosure

ra E, Kocaballi B, Halamka J, Laranjo L. The digital scribe. NPJ Digit Med. 2018;1:58. — Foundational perspective on autom
mentation and its safety and workflow implications.

en IG. Informed consent and medical artificial intelligence: what to tell the patient? Georgetown Law Journal. 2020;108:1425–1
consent-and-disclosure analysis behind the individual-vs-institutional distinction; pair with the Part B role-play.

rican Medical Association. Professionalism in Health Care Systems. Code of Medical Ethics, Opinion 11.2.1. https://code-me
s.ama-assn.org/ethics-opinions/professionalism-health-care-systems — Institutional conditions for professional judgment, care
responsible use of decision-support systems.

tability and automation bias

dard K, Roudsari A, Wyatt JC. Automation bias: a systematic review of frequency, effect mediators, and mitigators. J Am Me
c. 2012;19(1):121–127. — Automation bias as a documented, measurable phenomenon; grounds the accountability teaching p
D, Coiera E. Automation bias and verification complexity: a systematic review. J Am Med Inform Assoc. 2017;24(2):423–431.
cation effort shapes automation bias; optional companion to Goddard.
berg CB, Adams L, Blumenthal D, et al. To do no harm — and the most good — with AI in health care. Nat Med. 2024;30(3)
co-published in NEJM AI, doi:10.1056/AIp2400036). — The professional posture for AI deployment;
ande A. The Checklist Manifesto. Metropolitan Books; 2009 (excerpts). — Retaining ownership and judgment amid tools that a
ition; the most readable single source for the session's mindset.