# Curriculum Teaching and Editing Guide

Five-session AI curriculum • Reformatted 5 November 2026

The package uses the supplied Shapiro Institute PowerPoint template throughout. It contains five editable lecture decks, facilitator notes on every slide, and twenty supporting Word documents. This guide records the design choices and substantive content corrections made during preparation.

## Package contents

| Session | Lecture slides | Supporting documents |
|---|---|---|
| **1. AI Concepts in Healthcare** | 26 | Activity; alignment/evaluation; MCQs; PBL cases |
| **2. AI in Clinical Skills and Assessment** | 31 | Activity; alignment/evaluation; MCQs; PBL cases |
| **3. AI Limitations and Biases** | 27 | Activity; alignment/evaluation; MCQs; PBL cases |
| **4. AI Ethics** | 26 | Activity; alignment/evaluation; MCQs; PBL cases |
| **5. AI Professionalism** | 27 | Activity; alignment/evaluation; MCQs; PBL cases |

**Total: 137 slides.** Session 4 uses Structured Controversy as its activity document. The slide map lists original and final slide numbers and titles. Reference slides and crowded content have been split where useful; the original lecture set contained 129 slides.

### Source selection

The latest teaching versions in the supplied archive were used. Session 3 uses the 12 October lecture in Final Edits Complete and its final PBL version. Session 5 uses the November 4 lecture and the 1015 review-changes-applied supporting files, with the accompanying alignment document. Earlier drafts, duplicate versions, and reviewer correspondence are not included in the teaching package.

## Editing the materials

- **PowerPoint.** Titles, body text, references, and the summary table remain native editable objects. The template logos and curriculum URL appear throughout. Slide titles use Aptos Display and body text uses Aptos, with a white background and restrained navy emphasis. Keep body text near its existing size; split a crowded slide or move elaboration into notes.
- **Speaker notes.** Open the Notes pane or Notes Page view in PowerPoint. Notes explain the teaching purpose, provide discussion prompts and expected answers where relevant, qualify evidence, and connect adjacent concepts. Full approved learning-objective wording is retained in objective-slide notes; on-screen objectives are shorter for readability.
- **Word.** Headings, lists, tables, and page numbering use native Word elements. Most documents are portrait; alignment matrices are landscape. Arial provides a broadly available sans-serif match to the slide design. Edit named heading styles to change document-wide formatting.
- **Student and faculty copies.** MCQ explanations, PBL facilitator guides, and activity keys remain in the faculty documents. Extract the student-facing sections for assessment use. The Session 1 scripted transcript key begins on its own page so the planted error can remain hidden until debriefing.
- **Teaching sequence.** Retain the lecture–activity–PBL relationships in each session's alignment document. Case answers are not shown in advance in the professionalism lecture. Source slide

references have been updated for slide splits; several existing alignment references were also corrected by topic.

## Content changes for review

The primary task was presentation and facilitation quality. Clear inconsistencies, incomplete teaching examples, and overstatements encountered in that work were corrected. The following changes are substantive and should be included in the editorial sign-off; this was not an exhaustive independent revalidation of every clinical statement or every citation.

### Session 1: completed the offline prompt lab.

Replaced the incomplete transcript placeholders with explicitly constructed A/B/C examples. Transcript B contains a planted BUN:creatinine error; its identification and explanation are confined to the faculty key. Transcript C includes source-checking targets and qualifies the limitations of urinary indices. Faculty should select and confirm the authorized reference students will actually use.

### Session 1: corrected clinical and numerical examples.

Separated etiologic AKI categories from KDIGO severity staging; clarified the typical left-ventricular pump-failure example; and repaired the low-prevalence screening calculation. A 95%-accurate classifier can have zero sensitivity, but cannot have sensitivity below zero. The worked example now uses explicit patient counts.

### Across sessions: qualified claims about language models.

Replaced categorical statements that language models cannot reason or never retrieve information with distinctions among token generation, retrieval, system capabilities, and verification. Neither fluent output nor self-checking establishes truth; retrieval can help without eliminating fabrication.

### Sessions 2 and 5: distinguished findings from teaching strategies.

**Goh et al.** is described as finding no statistically significant improvement in physician diagnostic-reasoning performance with access to the tested LLM, rather than proving equivalence. Commit-first and reconciliation routines are presented as curriculum strategies. The Budzyń colonoscopy study is described as observational, without attributing the decline causally to AI or generalizing it to every clinical skill.

### Sessions 3–5: corrected the sepsis-study framing.

**Wong et al.** retrospectively evaluated a model; the study did not deliver live alerts to clinicians. Bedside responses and automation-bias scenarios are identified as constructed teaching cases. External-validation failure is distinguished from longitudinal drift. FDA clearance is not attributed to that model or treated as a performance guarantee.

### Sessions 3 and 4: qualified bias and environmental claims.

The chest-radiograph underdiagnosis study is not said to establish one causal mechanism of historical under-documentation. IEA electricity figures are labeled as all data-center use, not AI alone. Water use and hardware replacement are described as context dependent rather than universal per-chat or fixed-lifecycle quantities.

### Across sessions: corrected ethics and accountability references.

AMA Opinion 11.2.1 is correctly titled Professionalism in Health Care Systems. Clinical duties remain explicit while recognizing that institutions and vendors may also bear responsibilities, depending on the circumstances and jurisdiction.

### Session 5: clarified the statin and scribe cases.

The statin explanation uses ADA 2026 guidance and distinguishes moderate-intensity treatment from higher-risk indications for high-intensity treatment. Scribe timing, student participation, and attestation are labeled as assumptions of the fictional clinic, not universal licensing rules.

### Supporting documents: completed references and teaching structure.

Replaced reading placeholders with identified publications, including the Cooper–Rodman education perspective and Biro and Memon scribe studies. Removed draft/reviewer annotations and accepted tracked changes in the selected teaching files. Preserved assessment options and facilitator explanations while improving hierarchy and pagination.

## Sources for the principal corrections


- **Goh E, et al.** JAMA Network Open. 2024;7:e2440969. https://doi.org/10.1001/jamanetworkopen.2024.40969
- **Budzyń K, et al.** Lancet Gastroenterology & Hepatology. 2025;10:896–903. https://doi.org/10.1016/S2468-1253(25)00133-5
- **Wong A, et al.** JAMA Internal Medicine. 2021;181:1065–1070. https://doi.org/10.1001/jamainternmed.2021.2626
- **Seyyed-Kalantari L, et al.** Nature Medicine. 2021;27:2176–2182. https://doi.org/10.1038/s41591-021-01595-0
- **AMA.** Professionalism in Health Care Systems, Opinion 11.2.1. https://code-medical-ethics.ama-assn.org/ethics-opinions/professionalism-health-care-systems
- **Mello MM, Guha N.** New England Journal of Medicine. 2024;390:271–278. https://doi.org/10.1056/NEJMhle2308901
- **International Energy Agency.** Energy and AI. 2025. https://www.iea.org/reports/energy-and-ai/energy-demand-from-ai
- **Li P, et al.** Communications of the ACM. 2025;68(7):54–61. https://doi.org/10.1145/3724499
- **ADA.** Standards of Care in Diabetes—2026, Section 10, recommendations 10.18 and 10.20. https://diabetesjournals.org/care/article/49/Supplement_1/S216/163933/10-Cardiovascular-Disease-and-Risk-Management
- **KDIGO.** Clinical Practice Guideline for Acute Kidney Injury. 2012. https://kdigo.org/guidelines/acute-kidney-injury/
- **Merck Manual Professional.** Acute Kidney Injury; Urinary Diagnostic Indices in Prerenal Acute Kidney Injury and Acute Tubular Injury; Tubulointerstitial Nephritis. Use the current authorized course resource for student verification.
- **Cooper A, Rodman A.** New England Journal of Medicine. 2023;389:385–387. https://doi.org/10.1056/NEJMp2304993
- **Biro J, et al.** Journal of Medical Internet Research. 2025;27:e64993. https://doi.org/10.2196/64993
- **Memon S, et al.** BMC Health Services Research. 2026;26:182. https://doi.org/10.1186/s12913-025-13954-5