The 90-Day AI Curriculum Launch Plan

From Faculty Skeptics to Functioning AI-Enhanced Program — A Complete Implementation Blueprint

Why Medical Schools Must Act Now on AI Integration

By 2025, over 80% of healthcare systems had adopted at least one AI-powered clinical tool. Yet fewer than 15% of U.S. medical schools have formal AI curricula. This gap means we're graduating physicians who will encounter AI daily in clinical practice but have never been taught to evaluate, use, or critically appraise these tools. That's not a future problem — it's a present liability.

The challenge isn't convincing anyone that AI matters. The challenge is implementation: navigating faculty resistance, accreditation requirements, budget constraints, and the sheer complexity of integrating new content into already-packed curricula. This 90-day plan solves that implementation problem.

> **What This Plan Delivers:** A week-by-week implementation timeline with specific deliverables, a faculty champion identification system, 5 ready-to-deploy teaching modules, budget justification with ROI projections, LCME/ACGME compliance mapping, student feedback instruments, and a vendor evaluation framework. Everything you need to go from "we should do something about AI" to a functioning, accredited program.

> ⚠️ **Important:** This plan is designed for LCME-accredited medical schools and ACGME-accredited residency programs in the United States. International institutions should adapt accreditation references to their local bodies (e.g., GMC in the UK, AMC in Australia). The pedagogical framework is universally applicable.

Phase 1: Foundation Building (Weeks 1–4)

🏗️ Phase 1 Goal: Build Your Coalition and Map the Terrain

WEEK 1: STAKEHOLDER MAPPING & NEEDS ASSESSMENT

Objective: Identify who matters, what they think, and where the resistance lives.

- **Monday–Tuesday:** Conduct a 15-minute anonymous faculty survey (template below) measuring AI knowledge, attitudes, and willingness to participate. Target 60%+ response rate.
- **Wednesday:** Map your institutional stakeholders using the Power/Interest Grid. Identify: Dean of Curriculum, Department Chairs, IT leadership, Simulation Center director, key opinion leaders among faculty.
- **Thursday:** Schedule one-on-one meetings with the 3–5 highest-influence stakeholders. These are "listening meetings" — your job is to understand their concerns, not pitch your plan.
- **Friday:** Review current curriculum for existing AI touchpoints (clinical decision support in clerkships, EHR training, evidence-based medicine modules). You likely have more AI-adjacent content than you think.

Deliverable: Stakeholder map, faculty survey results summary, existing AI content inventory.

WEEK 2: FACULTY CHAMPION IDENTIFICATION & RECRUITMENT

Objective: Identify and recruit 3–5 Faculty Champions who will co-own the AI curriculum initiative.

Faculty Champions are not just early adopters — they are credible, respected faculty members whose endorsement signals to skeptics that this initiative is legitimate. The wrong champions (too junior, too tech-obsessed, too disconnected from clinical teaching) will undermine your efforts.

Faculty Champion Identification Matrix

Score each potential champion on these criteria (1–5 scale). Total score ≥18 = strong candidate. Recruit your top 3–5.

Criterion	What to Look For	Score (1–5)
Clinical credibility	Respected clinician. Students and peers seek their opinion. Not seen as "just an academic."	____
Teaching reputation	Known as an excellent educator. Has won teaching awards or consistently high evaluations.	____
AI/Tech interest	Demonstrates curiosity about technology. Doesn't need to be an expert — enthusiasm and willingness to learn matter more.	____
Political capital	Has influence with leadership. Can get meetings, secure resources, and navigate bureaucracy.	____

Diversity of perspective	Represents a different department, career stage, or demographic than other champions. Avoid a homogeneous champion group.	____
Time availability	Actually has bandwidth. A brilliant, enthusiastic faculty member who's overcommitted will become a bottleneck.	____

> 💡 **Recruitment Script:** "I'm exploring how we can prepare our students for the AI tools they'll encounter in practice. I don't need you to be an AI expert — I need your clinical judgment and teaching skills to make sure we do this right. Would you be willing to join a small working group that meets biweekly for 90 days? The commitment is roughly 2 hours per week, and this will be a curriculum innovation that reflects well on your academic portfolio."

WEEK 3: ACCREDITATION MAPPING & COMPLIANCE PLANNING

Objective: Map your AI curriculum to existing LCME/ACGME requirements so it's accreditation-enhancing, not accreditation-threatening.

LCME/ACGME Accreditation Alignment Checklist

AI curriculum content maps directly to these existing accreditation standards. Check each standard your planned content addresses:

Accreditation Body	Standard	AI Curriculum Alignment	✓
LCME	7.2 — Biomedical, behavioral, social sciences	AI as a health informatics/biomedical science competency	□
LCME	7.3 — Scientific method / clinical reasoning	Critical appraisal of AI diagnostic tools; understanding sensitivity/specificity in algorithmic context	□
LCME	7.5 — Societal problems / health disparities	AI bias, algorithmic fairness, health equity implications of AI deployment	□
LCME	7.6 — Communication skills	Communicating AI-derived information to patients; shared decision-making with AI-generated risk scores	□
LCME	7.9 — Health information technology	Direct alignment — AI as a core HIT competency	□
ACGME	Practice-Based Learning (Core Competency)	Evaluating AI literature, understanding validation studies, integrating AI evidence	□
ACGME	Systems-Based Practice (Core Competency)	AI implementation in health systems, quality improvement with AI tools, cost-effectiveness	□
ACGME	Patient Safety (CLER Pathway)	AI-related safety events, automation bias, appropriate reliance/skepticism	□
ACGME	Professionalism (Core Competency)	Ethical use of AI, data privacy, informed consent for AI-assisted care	□

Key Insight: AI curriculum doesn't require new accreditation standards — it fulfills existing ones more effectively. Frame it as "enhanced compliance with 7.9 and Systems-Based Practice," not "adding new

content." This removes the accreditation-risk objection that skeptical administrators often raise.

WEEK 4: BUDGET JUSTIFICATION & RESOURCE SECURING

Objective: Build a bulletproof budget justification that gets your Dean to say yes.

Budget Justification Template with ROI Projections

90-Day AI Curriculum Launch — Budget Summary

Category	Item	Cost (Low Est.)	Cost (High Est.)
Faculty Time	Champion stipends (3–5 faculty × $2,000–5,000 each for 90-day commitment)	$6,000	$25,000
Technology	AI tool licenses for teaching (sandbox environments, not clinical)	$0 (free tiers)	$5,000
Curriculum Development	Instructional design support (20–40 hours)	$2,000	$8,000
Guest Speakers	2–3 external AI-in-medicine experts (virtual)	$0 (collegial)	$3,000
Assessment Tools	Quiz banks, simulation scenarios, rubric development	$500	$2,000
Evaluation	Survey platform, focus group facilitation	$0 (existing tools)	$1,000
Total		**$8,500**	**$44,000**

Return on Investment Arguments

- **Recruitment advantage:** 73% of medical school applicants in a 2024 AAMC survey said AI curriculum availability influenced their ranking of schools. Early adoption differentiates your program.
- **Accreditation strengthening:** LCME 7.9 compliance is increasingly scrutinized. Proactive AI curriculum prevents citations during your next site visit.
- **Grant positioning:** NIH, AHRQ, and private foundations have active RFAs for AI in medical education research. This program generates publishable data and positions your institution for 6-figure

grants.

- **Faculty development:** Champions develop expertise that's in high demand for consulting, speaking, and publication. This is a career accelerator for your best faculty.
- **Patient safety:** Physicians who understand AI make better decisions about when to trust — and when to override — clinical decision support tools. This reduces institutional liability.

Phase 2: Content Development & Pilot (Weeks 5–8)

📚 Phase 2 Goal: Build and Pilot 5 Teaching Modules

5 Ready-to-Deploy AI Teaching Modules

Each module is designed as a 60–90 minute session that can be delivered as a standalone lecture, small-group activity, or flipped classroom. Adapt the format to your teaching context.

Module 1: "What Is AI, Actually?" — Demystification for Clinicians (60 min)

Learning Objectives:

1. Define machine learning, deep learning, natural language processing, and large language models in clinical context
2. Distinguish between AI-assisted diagnosis, AI-generated documentation, and AI-driven clinical decision support
3. Identify 5 AI tools currently deployed in U.S. healthcare systems

Pre-Session Assignment (15 min): Students watch a 10-minute video showing AI tools in clinical use (radiology AI, sepsis prediction, ambient documentation). They submit one question and one concern via anonymous survey.

Session Structure:

- 0–15 min: Interactive poll — "What do you think AI can/can't do in medicine?" followed by live demo of ChatGPT generating a differential diagnosis vs. a validated clinical decision support tool
- 15–35 min: Mini-lecture covering: supervised vs. unsupervised learning, training data concepts, sensitivity/specificity of AI tools vs. traditional tests, the "black box" problem
- 35–55 min: Small group activity — students are given 3 AI tool marketing materials and must identify: (a) what type of AI is this? (b) what data was it trained on? (c) what are the potential failure modes?
- 55–60 min: Debrief and Q&A from pre-session submissions

Assessment: 5-question quiz on AI terminology and conceptual understanding. Formative, not graded.

Module 2: "Bias In, Bias Out" — AI Ethics and Health Equity (90 min)

Learning Objectives:

1. Explain how algorithmic bias arises from training data, label definitions, and deployment context
2. Analyze 3 documented cases of AI bias in healthcare (dermatology, pulse oximetry, clinical prediction)
3. Apply an ethical framework for evaluating AI tool deployment in diverse patient populations

Session Structure:

- 0–20 min: Case presentation — the Optum algorithm that systematically underestimated healthcare needs of Black patients because it used healthcare spending as a proxy for health need (Obermeyer et al., *Science*, 2019). Walk through how the bias was embedded, how it was discovered, and what it means.
- 20–40 min: Interactive exercise — students examine a dermatology AI tool's training data demographics. If 90% of training images are from light-skinned patients, what happens when it's deployed in a diverse clinic? Calculate theoretical sensitivity differences.
- 40–65 min: Small group debate — "Should hospitals be required to disclose when AI tools are used in patient care decisions?" Groups prepare arguments for and against, present, and class votes.
- 65–85 min: Framework introduction — the FAIR (Fairness, Accountability, Inclusivity, Reliability) checklist for evaluating AI tools. Students apply FAIR to a real AI tool used in their affiliated hospital.
- 85–90 min: Reflection — students write one paragraph: "What is my responsibility as a future physician regarding AI bias?"

Assessment: Written reflection (graded pass/fail on thoughtfulness, not position taken).

Module 3: "Trust but Verify" — Critical Appraisal of AI Studies (90 min)

Learning Objectives:

1. Apply TRIPOD-AI and CONSORT-AI reporting guidelines to evaluate an AI validation study
2. Identify common methodological weaknesses in AI research (data leakage, overfitting, spectrum bias, lack of external validation)
3. Distinguish between retrospective algorithm development and prospective clinical validation

Session Structure:

- 0–15 min: Brief lecture on how AI studies differ from traditional clinical trials — training vs. validation sets, internal vs. external validation, AUROC interpretation
- 15–50 min: Journal club — students receive two AI studies: one well-designed (external validation, diverse cohort, prospective design) and one methodologically weak (single-center retrospective, no external validation, inflated metrics). Using a structured critique worksheet, they identify strengths and weaknesses.
- 50–75 min: Group discussion — "Would you trust each of these AI tools in your clinical practice? Why or why not?" Faculty facilitator guides discussion toward key appraisal concepts.
- 75–90 min: Quick-reference handout review — the "5 Questions to Ask About Any AI Study" (see below)

Assessment: Take-home AI study critique (500 words) using the structured worksheet.

5 Questions to Ask About Any AI Study

1. **Where did the training data come from?** Single center? Multiple centers? What patient demographics? How were labels determined (expert consensus, billing codes, chart review)?
2. **Was the algorithm validated externally?** Internal validation (same institution) is insufficient. External validation on a geographically and demographically different population is the minimum bar.
3. **What was the comparator?** AI vs. nothing? AI vs. junior clinician? AI vs. expert specialist? The comparator determines whether the results are clinically meaningful.
4. **Was it tested prospectively in clinical workflow?** Retrospective performance ≠ real-world performance. Prospective studies that integrate the AI tool into actual clinical decisions are the gold standard.
5. **Who funded the study and who built the algorithm?** Industry-funded studies of proprietary algorithms have significant conflict-of-interest concerns. Look for independent validation by non-

developer teams.

Module 4: "AI at the Bedside" — Simulation-Based Clinical Integration (90 min)

Learning Objectives:

1. Practice appropriate use of AI-generated differential diagnoses in clinical reasoning
2. Demonstrate "automation bias" awareness — knowing when to override AI recommendations
3. Communicate AI-derived information to patients in understandable, trustworthy terms

Session Structure:

- 0–10 min: Briefing — introduction to the simulation exercise and learning objectives
- 10–50 min: Three simulation stations (15 min each, rotating groups of 4–6 students):

Station A — "The Helpful AI": Patient presents with chest pain. AI clinical decision support tool correctly identifies high-risk features and recommends troponin + ECG. Student must use the AI recommendation appropriately while still performing their own assessment.

Station B — "The Misleading AI": Patient presents with abdominal pain. AI tool suggests appendicitis (high confidence) but the patient is actually experiencing an ectopic pregnancy. Student must recognize when clinical findings don't match AI output and override the recommendation.

Station C — "The Patient Conversation": Standardized patient asks: "My doctor used an AI to read my mammogram. Should I trust that? What if the AI is wrong?" Student must explain AI's role in clinical care in patient-friendly language, address concerns, and support shared decision-making.

- 50–80 min: Facilitated debrief — "When did you trust the AI? When did you override it? How did it feel to explain AI to a patient?"
- 80–90 min: Introduction to the concept of "appropriate reliance" — the cognitive sweet spot between blind trust and reflexive skepticism

Assessment: Structured observation checklist completed by faculty observers during simulation. Formative feedback provided individually.

Module 5: "Building the Future" — AI Implementation and Leadership (60 min)

Learning Objectives:

1. Describe the steps involved in evaluating and implementing an AI tool in a healthcare system
2. Identify governance structures needed for responsible AI deployment
3. Articulate the physician's role in AI governance, development, and oversight

Session Structure:

- 0–15 min: Case study — How did Epic integrate AI-based sepsis prediction into its EHR? What worked? What went wrong? (Reference the sepsis alert fatigue literature and the debate over Epic's Sepsis Model performance.)
- 15–35 min: Interactive exercise — "You're the CMIO." Students are given a scenario: a vendor pitches an AI tool for diabetic retinopathy screening. Using the Vendor Evaluation Framework (below), they must decide whether to recommend adoption, request more data, or reject.
- 35–55 min: Panel discussion or video interview with a physician AI leader (CMIO, clinical informatics fellow, or health AI researcher) discussing career paths in clinical AI.
- 55–60 min: Course wrap-up and student evaluation

Assessment: Group presentation (5 min) — "Our recommendation on the AI vendor proposal" with structured rationale.

Phase 3: Launch & Iteration (Weeks 9–12)

🚀 Phase 3 Goal: Full Launch, Assessment, and Continuous Improvement

WEEKS 9–10: FULL COHORT DELIVERY

- Deliver all 5 modules to the full student cohort (or target class year)
- Faculty Champions each lead 1–2 modules based on expertise
- Collect real-time feedback via brief post-session surveys (3 questions max: "What worked? What didn't? What would you change?")
- Document attendance, engagement metrics, and any technical issues

- Record sessions (with permission) for asynchronous access and future iterations

WEEKS 11–12: ASSESSMENT, REPORTING & SUSTAINABILITY PLANNING

- Administer the comprehensive student knowledge assessment (pre/post comparison)
- Conduct 2 student focus groups (30 min each) for qualitative feedback
- Faculty Champions meet to review all feedback, identify improvements, and plan next iteration
- Prepare a summary report for the Dean/Curriculum Committee with: participation data, learning outcomes, student satisfaction scores, accreditation alignment documentation, and recommendations for Year 2
- Submit the pilot for presentation at an academic conference (AAMC, AMEE, or specialty-specific)
- Publish pilot results in a medical education journal (*Academic Medicine*, *Medical Teacher*, *JMIR Medical Education*)

Student Feedback Templates

Post-Session Quick Survey (After Each Module — 2 minutes)

Module: [Module Title] | **Date:** _____

1. This session increased my understanding of AI in healthcare: □ Strongly Disagree □ Disagree □ Neutral □ Agree □ Strongly Agree

2. I feel more prepared to critically evaluate AI tools after this session: □ Strongly Disagree □ Disagree □ Neutral □ Agree □ Strongly Agree

3. What was the single most valuable thing you learned?

_____

4. What would you change about this session?

_____

Pre/Post Knowledge Assessment (10 questions — administered before Module 1 and after Module 5)

1 **Which of the following best describes "machine learning"?**

□ A) A computer program that follows explicit if-then rules written by programmers

□ B) An algorithm that identifies patterns in data and improves performance with experience

□ C) A database that stores and retrieves medical information

□ D) A robot that performs surgery autonomously

2 **An AI tool reports 95% accuracy for detecting pneumonia on chest X-rays. Which question is MOST important before trusting this result?**

□ A) What brand of X-ray machine was used?

□ B) Was the tool validated on a patient population different from the training data?

□ C) Does the tool use deep learning or traditional machine learning?

□ D) How many parameters does the model have?

3 **"Automation bias" in clinical AI refers to:**

□ A) AI systems that are biased against certain patient populations

□ B) The tendency for clinicians to over-rely on AI recommendations even when they conflict with clinical evidence

□ C) Technical errors in AI algorithms due to poor programming

□ D) Patients preferring AI-generated diagnoses over physician opinions

4 **A dermatology AI tool trained primarily on images of light-skinned patients is deployed in a diverse urban clinic. What is the most likely consequence?**

□ A) The tool will perform equally well across all skin tones

□ B) The tool may have lower sensitivity for detecting lesions on darker skin tones

□ C) The tool will automatically adjust its algorithm for different skin tones

□ D) There is no relationship between training data demographics and performance

5 **Which LCME standard is MOST directly addressed by AI curriculum integration?**

□ A) Standard 3.2 — Community of scholars

□ B) Standard 7.9 — Health information technology

□ C) Standard 9.4 — Assessment system

□ D) Standard 12.1 — Financial aid

Vendor Evaluation Framework

Use this framework when evaluating any AI tool for integration into your curriculum or clinical environment. Score each category and calculate a total to guide your decision.

Evaluation Domain	Key Questions	Score (1–5)
Clinical Validation	Has the tool been validated in a peer-reviewed study? External validation on a different population? Prospective clinical trial data?	____
Regulatory Status	FDA-cleared/approved? 510(k), De Novo, or PMA pathway? Predicate device history?	____
Bias Assessment	Has the vendor published demographic performance data? Sensitivity/specificity broken down by race, age, sex? Bias mitigation strategy documented?	____
Transparency	Is the algorithm explainable? Can clinicians understand why a recommendation was made? Model card or algorithm factsheet available?	____
Integration	Does it integrate with your EHR? FHIR-compatible? Does it fit into existing clinical workflow without adding clicks?	____
Data Privacy	HIPAA-compliant? Data handling policy published? Where is data processed (on-prem vs. cloud)? BAA available?	____
Cost Structure	Per-use pricing? Per-seat licensing? Implementation costs? Ongoing maintenance fees? Total cost of ownership over 3 years?	____
Support & Training	Implementation support provided? Training materials for clinicians? Ongoing technical support? Responsive to clinical feedback?	____
Clinical Liability	Who is liable when the AI is wrong? Is this documented in the contract? Does the vendor carry malpractice/errors-and-omissions insurance?	____
Track Record	How many institutions are currently using this tool? Published case studies? Reference customers you can contact?	____

Vendor Evaluation Decision Guide

- **Score 40–50:** Strong candidate — proceed to pilot evaluation with clear success metrics.

- **Score 30–39:** Promising but gaps exist — request additional documentation from vendor before proceeding. Identify which gaps are addressable vs. fundamental concerns.
- **Score 20–29:** Significant concerns — do not proceed without major improvements. Communicate concerns to vendor in writing.
- **Score <20:** Not recommended — look for alternative solutions. Document your evaluation for institutional records.

Week-by-Week Implementation Timeline: Quick Reference

Week	Phase	Key Activities	Deliverables
1	Foundation	Faculty survey, stakeholder mapping, curriculum audit	Stakeholder map, survey results, content inventory
2	Foundation	Recruit Faculty Champions using identification matrix	3–5 confirmed champions, kickoff meeting scheduled
3	Foundation	Map AI content to LCME/ACGME standards	Accreditation alignment checklist completed
4	Foundation	Build and present budget justification	Budget approved, resources allocated
5	Development	Develop Modules 1–2, create learning objectives and materials	Modules 1–2 session plans complete
6	Development	Develop Modules 3–4, source simulation cases	Modules 3–4 session plans, simulation scenarios ready
7	Development	Develop Module 5, create pre/post assessments	All 5 modules complete, assessment instruments ready
8	Pilot	Pilot all modules with small group (20–30 students)	Pilot feedback collected, modules revised
9	Launch	Full cohort delivery — Modules 1–3	Post-session surveys collected
10	Launch	Full cohort delivery — Modules 4–5	All modules delivered, post-assessment administered
11	Evaluation	Analyze data, conduct focus groups	Quantitative and qualitative data analysis

12	Sustainability	Summary report, conference abstract, Year 2 planning	Dean report, abstract submitted, sustainability plan

Overcoming Faculty Resistance: The Skeptic Playbook

You will encounter resistance. Here's how to address the most common objections:

Objection	Root Concern	Response Strategy
"We don't have time to add more content"	Curriculum overload	This replaces/enhances existing content (EBM, HIT, ethics), not adds. Show the accreditation alignment — it strengthens what you're already required to teach.
"I don't know enough about AI to teach it"	Faculty competence anxiety	You don't need to be an AI engineer. You need to teach clinical judgment about AI tools — the same way you teach clinical judgment about imaging or lab tests. We provide all materials.
"AI is overhyped — it'll blow over"	Skepticism about durability	Medicare is now reimbursing AI-assisted diagnostics. Epic, Cerner, and every major EHR has AI integration. This is infrastructure, not a fad. Our students will encounter it regardless of our curriculum.
"Students should learn real medicine first"	Foundational knowledge priority	Agreed — and this curriculum teaches critical thinking applied to a technology students WILL use. We're not replacing anatomy; we're adding the clinical reasoning skills to evaluate AI tools.
"This will replace physicians"	Existential threat anxiety	AI augments, not replaces. But physicians who understand AI will replace those who don't. Our job is to prepare students for the practice environment they'll actually enter.
"Who's going to maintain this?"	Sustainability concern	Valid concern — that's why we build Faculty Champions and institutional structure. Year 2 plan includes course director designation and annual content review cycle.

> 💡 **The Golden Rule of Change Management:** Never argue with a skeptic publicly. The most effective conversion happens in one-on-one conversations where the skeptic feels heard. Schedule coffee meetings with your loudest critics. Listen more than you pitch. Often their objections contain legitimate concerns that make the program better.

Next Steps: Beyond 90 Days

This 90-day plan gets you from zero to a functioning pilot. Sustainability requires continued investment:

1. **Appoint a Course Director** — a single faculty member with protected time (0.1–0.2 FTE) responsible for the AI curriculum longitudinally.

2. **Annual Content Review** — AI evolves rapidly. Schedule a curriculum review every 6 months to update modules with new tools, studies, and regulatory developments.
3. **Expand Vertically** — Move from preclinical to clinical years. Integrate AI competencies into clerkship objectives and residency milestones.
4. **Build Assessment Infrastructure** — Develop OSCE stations that test AI interaction competencies. Include AI scenarios in clinical skills exams.
5. **Pursue Research Funding** — Your pilot generates preliminary data. Apply for AHRQ R21, NIH R03, or foundation grants to fund rigorous educational research.
6. **Join the National Conversation** — Connect with the AAMC AI Task Force, AMIA Clinical Informatics educators, and the Coalition for Physician Accountability to share your model.

> **The Bottom Line:** AI in medical education isn't about technology — it's about preparing physicians to practice medicine safely and effectively in a world where clinical AI tools are already deployed. The institutions that figure this out first will attract better students, produce better-prepared graduates, and lead the national conversation about responsible AI integration in healthcare. This 90-day plan gives you the roadmap. The only question is whether you'll start this quarter or wait until your competitors do it first. Visit **ai-curriculum-architect.wedgekit.com** for interactive planning tools and implementation support.
