

Building a National Nutrition Curriculum—and Keeping it Current

The Nutrition in Medicine (NIM) story, University of North Carolina at Chapel Hill, 1995 onward

An educational resource can succeed—and still become difficult to sustain without continuing support.

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Q: Where did the story begin?

The Nutrition in Medicine (NIM) project began with a national problem: medical students needed a stronger foundation in preventive and therapeutic nutrition, but many medical schools lacked sufficient curricular time and faculty expertise to build a comprehensive program locally. The NIM team created a shared curriculum that schools could use without developing every component themselves. Beginning in 1995, the team distributed the curriculum free of charge to medical schools.

Q: What did the team build first?

The original curriculum was delivered through interactive CD-ROM modules spanning nutrition science, prevention, disease, the life course, and clinical care. The modules included learning objectives, patient cases, self-assessment, feedback, and opportunities to apply knowledge. The NIM team continued to refine the curriculum as nutrition science, educational technology, and national nutrition-education frameworks evolved. This gave schools with limited local nutrition expertise access to a credible and relatively consistent educational resource.

Q: What was the real challenge?

The challenge was not only creating good content. The modules had to fit many different medical-school curricula, compete for limited instructional time, remain technically accessible, and keep pace with changing nutrition science and clinical recommendations. A resource could be distributed nationally, but faculty still needed to know where to place it, how much of it to assign, and how to connect it with local objectives, clinical teaching, and assessment.

Q: How did the project respond?

The team repeatedly adapted the curriculum in response to surveys, user feedback, and changes in educational technology. NIM moved from larger CD-ROM titles to shorter, web-based instructional units. The web format reduced installation and technical-support problems, improved access, and made it easier to revise individual sections. The more modular design allowed faculty to select content according to learner needs, curricular location, and available time rather than requiring completion of a fixed course.

Q: How broad was its reach?

NIM achieved broad national and international reach. Project reports described distribution to all U.S. medical schools, use by most U.S. medical and osteopathic schools, and use by institutions in more than 20 countries. The team also conducted repeated national surveys of nutrition education, helping document the persistent educational gap and the reach of NIM materials. In a national survey of the 2012–2013 academic year, schools using NIM reported more nutrition-instruction hours than schools not using the courses.

Q: What did the educational approach add?

NIM went beyond recorded lectures. The web curriculum included interactive lessons, skill-building exercises, review questions, clinical cases, adaptive learning, and simulated patient encounters. Learners could work at their own pace, receive feedback, and repeat material when needed. The modules also addressed practical communication, including phrases and approaches for nutrition counseling and motivational interviewing. The team later developed shorter, clinically

focused instruction for residents and fellows. After a one-hour web-based module, obstetrics and gynecology residents and fellows reported improvement in several nutrition-related practices, including counseling about gestational weight gain and referral to a registered dietitian.

Q: What worked?

A clearly defined national need, an interdisciplinary team, external grant support, free access, credible content, repeated evaluation, and willingness to redesign the product all helped NIM grow. The curriculum was scalable and gave schools a way to add nutrition education despite limited local expertise. The national surveys strengthened the case for action, while the shift to smaller online units made the material easier to integrate into diverse curricula.

Q: What proved difficult to sustain?

The long-term maintenance model did not become as durable as the educational product. The modules required continuing scientific review, content revision, instructional design, software maintenance, technical support, assessment updates, and coordination. Insufficient continuing funding made it difficult to keep the modules current and maintain the platform. The central problem was not that NIM lacked value or users; it was that a sophisticated national resource could not be updated indefinitely through time-limited grants and volunteer effort alone.

Q: What may be learned from the experience?

The NIM experience shows that interactive, computer-based nutrition instruction can be widely disseminated, adapted for different learners, and used to address gaps in medical nutrition education. It also shows that development and dissemination are only part of the work: long-term use depends on continuing scientific review, technical support, and resources for updating and maintenance.

Q: What lessons may be transferable for nutrition champions?

The NIM experience may be useful to nutrition champions because it began with a documented educational gap, created shared resources for schools with limited local expertise, and adapted those resources as educational needs and technology changed. The move toward shorter, interactive, clinically focused instruction increased flexibility across learner levels. The later maintenance challenges also draw attention to the continuing funding and technical support required to keep educational resources current.

Q: What may be relevant for the Physician Nutrition Learning Hub?

The NIM experience demonstrates both the value of shared educational resources and the importance of planning for their long-term maintenance.

References

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