

Finding Nutrition in a Crowded Medical Curriculum
A Boston University (BU) community implementation story, 2005-2023
Curriculum change rarely happens overnight. In our case, it only took about 18 years.

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Q: Where did the story begin?

It began with students, before there was a curriculum plan. Soon after I joined Boston Medical Center, medical students presented data at a regional American Medical Association (AMA) chapter meeting showing that students felt poorly prepared to counsel patients about nutrition. At the same time, I was serving on a Harvard medical education committee, where faculty were also asking how nutrition could fit into medical training after losing their dedicated course. The students' presentation became the spark for a long effort to find nutrition, name it, and protect it in a crowded curriculum.

Q: What was the real challenge?

Nutrition was not simply missing; it was hiding in plain sight and hard to follow over time. Content could appear, disappear, or reappear across courses and clinical settings. Some teaching was present but hidden under metabolism, gastrointestinal, endocrinology, pediatrics, oncology, public health, or prevention. The challenge was to find it, name it, connect it to clinical care, and sustain it.

Q: What did you build first?

On the Dean's recommendation, we started with an advanced elective in pediatric nutrition as proof of concept. It showed that interprofessional expertise - a physician nutrition specialist, Registered Dietitian Nutritionists (RDNs), a licensed social worker, and students - could translate into medical student education, attract student interest, and help sustain nutrition-education funding for 14 years.

Q: Where were you able to insert nutrition?

We found natural entry points where nutrition connected to science or clinical care: gastrointestinal/nutrition, endocrinology, renal, metabolism, public health/prevention, and the mandatory third-year ambulatory care clerkship, where motivational interviewing supported nutrition counseling. In pediatrics, a monthly obesity vignette revealed knowledge gaps and helped accelerate curriculum review. Some clerkship content was later removed; a student later developed a new nutrition-counseling activity, but it was no longer mandatory and lacked RDN support.

Q: How did students help move the work forward?

Student Nutrition Awareness and Action Council (SNAAC) helped turn isolated efforts into a broader student-faculty process through advocacy, peer learning, community engagement, curriculum feedback, and presentations at John McCahan Education Day, Boston Nutrition Obesity

Research Center (NORC), AMA, American Society for Nutrition, and American College of Lifestyle Medicine meetings. Scholarships helped students build confidence, meet peers, and collaborate on events. SNAAC also received school funding matched by student fundraising. Early support from a former Harvard mentor helped activities across four Boston-area medical schools, although that support faded.

Q: What changed in the curriculum?

Documented hours with nutrition-related content increased from 20 hours in 2005 to 108+ hours by 2018. Excel grids tracked faculty names, physician/RDN involvement, course location, hours, and distribution across the four years; a web version helped students and faculty locate content. The grids became our way of asking, again and again: Where is nutrition now, who is teaching it, and is it still reaching students?

Q: What worked?

Starting small worked. The advanced elective created proof of concept, student concerns gave urgency, early funding made development possible, and the Nutrition Vertical Integration Group (VIG) gave the effort a home. The strongest ingredients were partnership and persistence: RDN/physician expertise, public health and education faculty, student advocacy, repeated curriculum review, and regular communication with education leadership.

Q: What did not work?

Nutrition remained fragile, especially once it entered the busy reality of clerkships. Content could move or disappear during redesign, discussion days shifted, and clinical work often took priority. Some activities became less durable when they were no longer required or lacked RDN involvement. SNAAC brought energy, but turnover made follow-up difficult, and counting hours did not capture depth, quality, assessment, or clinical application.

Q: What lessons did you learn?

Nutrition education has to be built as a system, not a single lecture. It needs a home, champions, student voice, RDN/physician partnership, repeated review, and a way to survive redesign. Hours matter, but they are not enough; schools also need to know where nutrition is taught, who teaches it, whether it reaches all students, and whether it connects to skills, assessment, and care.

Q: What is transferable?

Schools do not need to copy this model; every context is different. What is transferable is the process: start with a learner gap, build an interprofessional champion group, use keyword searches, course-director review, grids, or artificial intelligence (AI) mapping, and connect it to objectives, cases, assessment, counseling skills, and faculty support. The take-home lesson is not just to add nutrition. It is to keep asking whether nutrition is still there, accurate, and useful for learners.

References

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