

MEDICAL DIRECTOR ROLES & RESPONSIBILITIES



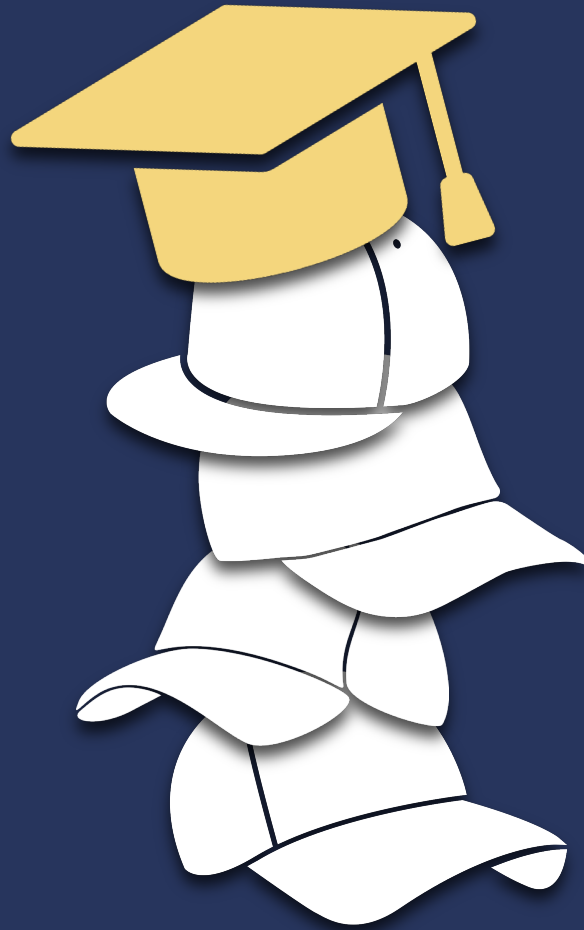
Maia Dorsett, MD PhD FAEMS

Medical Director, Monroe Community College Paramedic Program
Rochester, NY

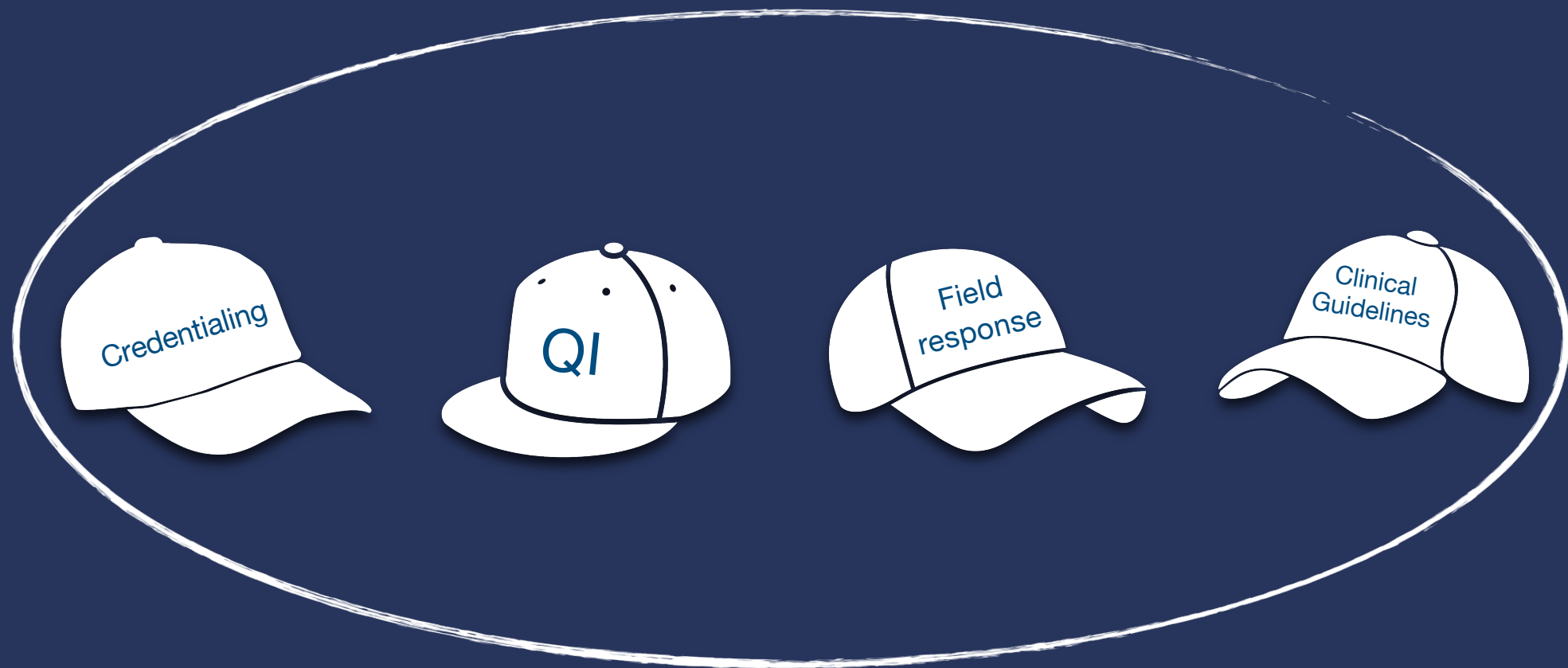
Who is here?

Please enter your name and
role in the chat

DISCLAIMER:



MEDICAL DIRECTOR

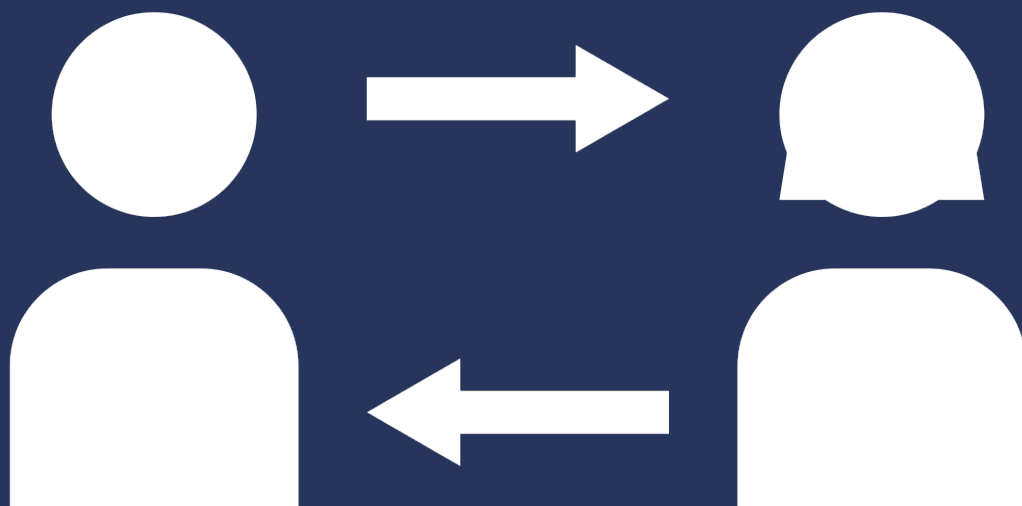




Graduation







Resource Deficiencies in Accredited Paramedic Programs

RAM Deficiency	Frequency (N = 406)
Medical director	14%
Facilities	13%
Financial resources	11%
Support personnel	11%
Physician interaction	11%
Program faculty	10%
Clinical resources	8%
Field resources	7%
Curriculum	7%
Learning resources	6%

Kaduce, M., Powell, J. R., Collard, L., Gage, C. B., Miller, M. G., & Panchal, A. R. (2024). Medical Directors, Facilities, and Finances: Resource Deficiencies in Accredited Paramedic Programs. *Prehospital Emergency Care*, 28(2), 326-332.

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Clinical resources	8%
Field resources	7%
Curriculum	7%
Learning resources	6%

**Limited interaction with
program and/or
students
(91%)**

**Lack of interaction with
students/program
(94%)**

Kaduce, M., Powell, J. R., Collard, L., Gage, C. B., Miller, M. G., & Panchal, A. R. (2024). Medical Directors, Facilities, and Finances: Resource Deficiencies in Accredited Paramedic Programs. *Prehospital Emergency Care*, 28(2), 326-332.



CoAEMSP INTERPRETATIONS OF THE CAAHEP 2023 STANDARDS AND GUIDELINES

for the Accreditation of Educational Programs in the EMS Professions

Standard III.B.2.a. Medical Director Responsibilities

The medical director must be responsible for medical oversight of the program, including but not limited to

- 1) Review and approve the educational content of the program to include didactic, laboratory, clinical experience, field experience, and capstone field to ensure it meets current standards of medical practice;
- 2) Review and approve the required minimum numbers for each of the required patient contacts and procedures listed in these Standards;
- 3) Review and approve the instruments and processes used to evaluate students in didactic, laboratory, clinical, field experience, and capstone field internship;
- 4) Review the progress of each student throughout the program, and assist in the determination of appropriate corrective measures;

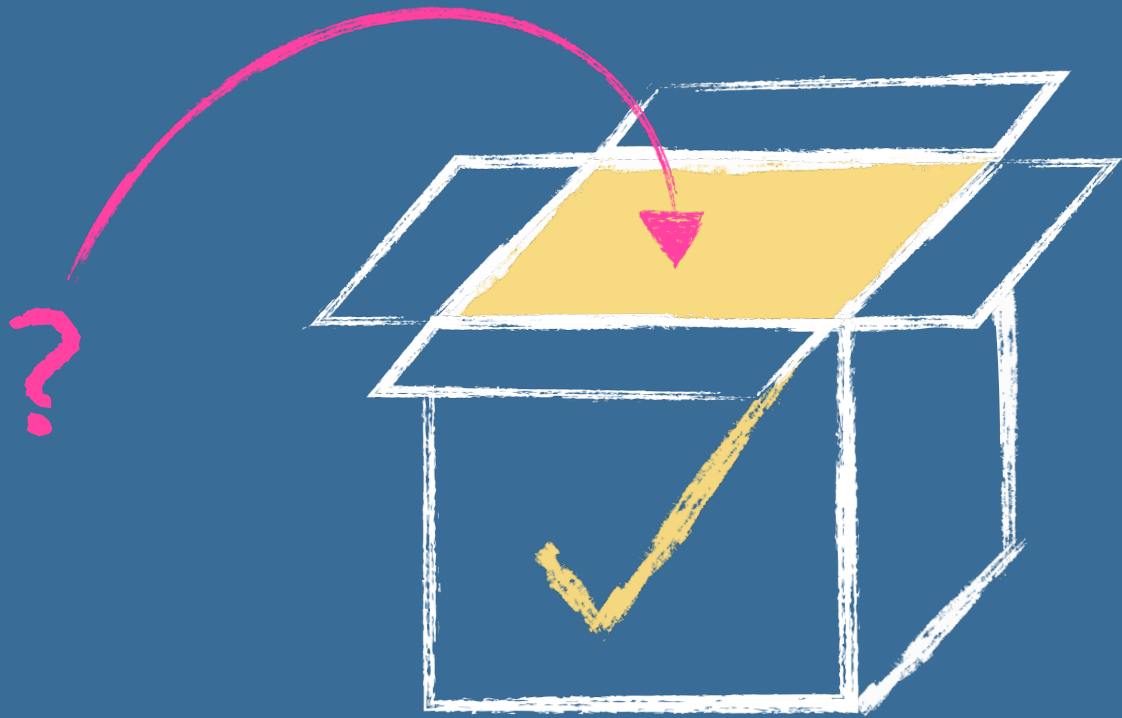
It is recommended that corrective measures occur in the cases of failing academic or clinical or field internship performance.

- 5) Ensure the competence of each graduate of the program in the cognitive, psychomotor, and affective domains;
- 6) Engage in cooperative involvement with the program director; and
- 7) Ensure the effectiveness and quality of any Medical Director responsibilities delegated to an Associate or Assistant Medical Director.

It is recommended that the Medical Director interaction be in a variety of settings, such as lecture, laboratory, clinical, capstone field internship. Interaction may be by synchronous electronic methods.







1

Review and approval of the educational content of the program to include didactic, laboratory, clinical experience, field experience, and capstone field internship to ensure it meets current standards of medical practice;

didactic

Curriculum review
Content review

laboratory

Simulation scenarios

clinical experience, field experience and capstone field internship

Rotations & Objectives

Mechanical versus manual chest compression for out-of-hospital cardiac arrest (PARAMEDIC): a pragmatic, cluster randomised controlled trial

Gavin D Perkins, Ranjit Lall, Tom Quinn, Charles D Deakin, Matthew W Cooke, Jessica Horton, Sarah E Lamb, Anne-Marie Slawther, Malcolm Woolward, Andy Carson, Mike Smyth, Richard Whitfield, Amanda Williams, Helen Pocock, John J M Black, John Wright, Kyre Harn, Simon Gates, PARAMEDIC trial collaborators*

Summary

Background Mechanical chest compression devices have the potential to help maintain high-quality cardiopulmonary resuscitation (CPR), but despite their increasing use, little evidence exists for their effectiveness. We aimed to study whether the introduction of LUCAS-2 mechanical CPR into front-line emergency response vehicles would improve survival from out-of-hospital cardiac arrest.

Methods The pre-hospital randomised assessment of a mechanical compression device in cardiac arrest (PARAMEDIC) trial was a pragmatic, cluster-randomised open-label trial including adults with non-traumatic, out-of-hospital cardiac arrest from four UK Ambulance Services (West Midlands, North East England, Wales, South Central). 91 urban and semi-urban ambulance stations were selected for participation. Clusters were ambulance service vehicles, which were randomly assigned (1:2) to LUCAS-2 or manual CPR. Patients received LUCAS-2 mechanical chest compression or manual chest compressions according to the first trial vehicle to arrive on scene. The primary outcome was survival at 30 days following cardiac arrest and was analysed by intention to treat. Ambulance dispatch staff and those collecting the primary outcome were masked to treatment allocation. Masking of the ambulance staff who delivered the interventions and reported initial response to treatment was not possible. The study is registered with Current Controlled Trials, number 15RCTN08233942.

Findings We enrolled 4471 eligible patients (1652 assigned to the LUCAS-2 group, 2819 assigned to the control group) between April 15, 2010 and June 10, 2013. 985 (60%) patients in the LUCAS-2 group received mechanical chest compression, and 11 (<1%) patients in the control group received LUCAS-2. In the intention-to-treat analysis, 30 day survival was similar in the LUCAS-2 group (104 [6%] of 1652 patients) and in the manual CPR group (193 [7%] of 2819 patients; adjusted odds ratio [OR] 0.86, 95% CI 0.64–1.15). No serious adverse events were noted. Seven clinical adverse events were reported in the LUCAS-2 group (three patients with chest bruising, two with chest lacerations, and two with blood in mouth). 15 device incidents occurred during operational use. No adverse or serious adverse events were reported in the manual group.

Interpretation We noted no evidence of improvement in 30 day survival with LUCAS-2 compared with manual compressions. On the basis of ours and other recent randomised trials, widespread adoption of mechanical CPR devices for routine use does not improve survival.

Funding National Institute for Health Research HTA – 07/37/69.

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Introduction

The burden of cardiac arrest out of hospital is substantial, with an estimated 424 000 cardiac arrests occurring each year of about in the USA¹ and 275 000 in Europe.² As few as one in 12 victims of cardiac arrest out of hospital survive to return home.^{3,4} High-quality chest compressions of sufficient depth⁵ and rate,⁶ with full recoil of the chest between compressions⁷ and avoidance of interruptions⁸ are crucial to survival. Maintenance of high-quality compressions during out-of-hospital resuscitation is difficult because of the small number of crew present, fatigue, patient access, competing tasks (eg, defibrillation, vascular access) and difficulty of performing resuscitation in a moving vehicle.⁹

Mechanical compression devices suitable for use in the pre-hospital environment have been developed to automate and potentially improve this process. At the time of initiating this study, one large randomised trial of a load distributing band mechanical device had been done and was terminated early because of the worsened long-term outcomes in patients allocated to mechanical compression.¹⁰ The subsequent Cochrane review reported insufficient evidence to conclude that mechanical chest compressions are associated with benefit or harm and their widespread use is not supported.¹¹ Since then, two further large randomised efficacy trials have been reported. The CIRC trial¹² assessed the load distributing band and reported it was equivalent to manual cardiopulmonary resuscitation



Lancet 2015; 385: 947–55

Published online November 16, 2014

[http://dx.doi.org/10.1016/S0140-6736\(14\)61895-9](http://dx.doi.org/10.1016/S0140-6736(14)61895-9)

See Comment page 520

*Collaborators listed at end of paper

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Heart of England NHS

Foundation Trust,

Birmingham, UK

(Prof G D Perkins), Surrey

Post-operative Anaesthesia

Critical care collaborative

Research Group, Faculty of

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University of Surrey, Guildford,

UK (Prof T Quinn M Phil,

Prof M Woolward MPH,

Prof C D Deakin MD), South

Central Ambulance Service

NHS Foundation Trust,

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University Hospital

Southampton NHS Foundation

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Hampshire (Prof C D Deakin),

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UK (Prof S E Lamb), West

Midlands Ambulance Service

NHS Foundation Trust, Boleby

Hill, UK (A Carson FRCP,

M Smyth), Welsh Ambulance

Service NHS Trust,

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(P Whitfield BSc, A Williams MA),

North East Ambulance Service

NHS Foundation Trust,

Newcastle upon Tyne, UK

(J Wright FRCM, K Harn FRCM),

and Royal Victoria Infirmary,

Newcastle upon Tyne, UK

(J Wright)





2

Review and approval of the required minimum numbers for each of the required patient contacts and procedures listed in these Standards;

3

Review and approval of the instruments and processes used to evaluate students in didactic, laboratory, clinical, field experience, and capstone field internship;

Before - review exam questions

After- exam analysis & discussion

Major/High Stakes Exam Analysis										
Program Name: _____										
Course Name: _____	Course Dates: _____									
Course Number: _____	Exam Date: _____									
Exam Name/Topic: _____	Lead Instructor: _____									
Number of students completing exam: _____										
Is statistical analysis of questions conducted? Y ☐ N ☐										
Highest Score: _____										
Lowest Score: _____										
Cut Score: _____										
Class Average: _____										
Class Median: _____										
Content areas receiving unexpected low scores _____ _____										
Recommendations from learning prescription if applicable _____ _____										
Changes made to exam if applicable _____ _____										
Strategies to address low performing areas _____ _____										
Program Director/Lead Instructor comments: _____ _____ _____										
<table border="1"><tr><td>Exam results reviewed with:</td><td>Y ☐ N ☐</td><td>Date: _____</td></tr><tr><td>Faculty</td><td>Y ☐ N ☐</td><td>Date: _____</td></tr><tr><td>Medical Director</td><td>Y ☐ N ☐</td><td>Date: _____</td></tr></table>		Exam results reviewed with:	Y ☐ N ☐	Date: _____	Faculty	Y ☐ N ☐	Date: _____	Medical Director	Y ☐ N ☐	Date: _____
Exam results reviewed with:	Y ☐ N ☐	Date: _____								
Faculty	Y ☐ N ☐	Date: _____								
Medical Director	Y ☐ N ☐	Date: _____								
Program Director: _____	Date: _____									

Revised 2021.01\Lisa's Place_In Progress\Website Templates\Instruments & Forms\Archived\High Stakes Exam Analysis PDF 2020.04.02.docx



MCC Paramedic Program: Global Rating Scale Assessment of Performance for Summative Psychomotor Evaluation

Date: _____

Candidate: _____

Scenario: _____

Evaluator: _____

Domain	N/A	1	2	3	4	5	Score	Comments
Systemic Assessment and Approach		Incomplete assessment		Adequate Assessment, minor flaws		Complete and structured assessment	of 5	
Physical Examination		Too little or unnecessary		Appropriate & suitable to situation		Very accurate & reasonable	of 5	
Vital Signs and Monitoring		Possibly unaware of critical condition		Attention to most important warning signs		Very adequate and anticipatory	of 5	
Patient positioning and movement		Disadvantageous or dangerous		Appropriate position after an acceptable time		Beneficial position during the scenario	of 5	
Handling of Equipment		Many difficulties with the equipment		Appropriate use of equipment		Advanced use of the equipment	of 5	
Therapy and Medication		Inadequate or harmful therapy		Adequate therapy, no harm		Sufficient therapy based on current guidelines	of 5	
Patient Safety		Many risk factors for patient safety		Few risk factors for patient safety occurred		Safe handling, maximal elimination of risk factors	of 5	
Leadership/Communication to team members		Dismissive or inappropriate communication with team members		Adequate task delegation, communication and response to feedback		Clear task delegation, communication and response to feedback	of 5	
Patient Communication		Dismissive of patient/family concerns		Used clear and appropriate language		Therapeutic and clear Communication	of 5	
Overall Performance		Unsafe		Competent		Exceptional	of 5	
Total							Of 50	

To meet minimum entry level competency, each student must score a minimum of a "3" in each domain.

Field Clinical Student Evaluation

Date : _____	Student Name: _____
Location: _____	Shift times: _____
Preceptor _____	Preceptor Signature: _____

	Below Expectations	Meets Expectations	Exceeds Expectations	Not observed
Domain	Ideally, below expectations or exceeds expectations should be accompanied by a comments on the back of this sheet*			
Affective				
Appearance				
Punctuality				
Interactions with patients and/or family				
Interactions with other health care providers				
Initiative				
Maintains composure under stress				
Cognitive				
Medical knowledge				
Clinical decision making				
Psychomotor/Patient Assessment & Management				
	Would allow to perform with close supervision	Would trust to perform with minimal supervision	Would trust to perform independently	Not observed
Intravenous access				
Airway Management				
Medication administration				
Fluid therapy				
Patient Management- cardiac, high acuity				
Patient Management - cardiac, low acuity				
Patient Management - respiratory, high acuity				
Patient Management - respiratory, low acuity				
Patient Management - Neuro				
Patient Management - Trauma, high acuity				
Patient Management - Trauma, low acuity				
Patient Management- Pediatrics				

Students: Form should be scanned in and uploaded into EMS Metrics.

4

Review of the progress of each student throughout the program, and assist in the determination of appropriate corrective measures;

It is recommended that corrective measures occur in the cases of failing academic or clinical or field internship performance.

5

Ensuring the competence of each graduate of the program in the cognitive, psychomotor, and affective domains;



Terminal Competency Form

CoAEMSP Program #: []

Program Sponsor Name: []

Program Level: [Please Select]

We hereby attest that this student has successfully completed all terminal competencies required for graduation from the educational program and has demonstrated competency in the cognitive, psychomotor, and affective domains to entry the profession. Based on this attestation we affirm the student is eligible to begin the examination and certification process.

♦ Standard III.B.2.a Medical Director responsibilities include a terminal competency form for each graduate signed and dated by the program Medical Director. If the CoAEMSP Terminal Competency Form is not used, the program's terminal competency form needs to include the attestation statement above.

Name of Graduate: []

PROGRAM REQUIREMENTS successfully and fully completed on []

Program Overall Score []

List of Written High Stakes Examinations (including the final cumulative summative examination)

	Score		Score
(1)	%	(12)	%
(2)	%	(13)	%
(3)	%	(14)	%
(4)	%	(15)	%
(5)	%	(16)	%
(6)	%	(17)	%
(7)	%	(18)	%
(8)	%	(19)	%
(9)	%	(20)	%
(10)	%	(21)	%
(11)	%	(22)	%

☐ Completed Student Minimum Competency (SMC) Matrix Requirements (required minimums, competencies, and patient contacts)

Terminal Competency Form

Page 2

- ☐ Documented Skill Competencies
- ☐ Affective Learning Domain Evaluations
- ☐ Clinical/Field Experience Tracking Records (attended all required areas, completed required competencies)
- ☐ Capstone Field Internship Tracking Records (number of team leads, achieved competencies)
- ☐ Graduation Requirements Report

Summative Comprehensive Final Evaluation

- ☐ Cognitive []
- ☐ Psychomotor []
- ☐ Affective []

☐ Academic Advising Documentation (each term)

☐ Student Counseling Form(s), as applicable

Medical Director Signature:
(secure digital or handwritten)

Date Approved: []

Program Director Signature:
(secure digital or handwritten)

Date Approved: []

Please Note: If the Associate or Assistant Medical Director has approved terminal competency, then the program must be able to provide evidence the program Medical Director has delegated this duty to the Associate or Assistant Medical Director for review during the site visit or at any point evidence is requested by CoAEMSP.

CARD COURSE CERTIFICATIONS (if applicable, prior to graduation):

Select	on	[]
Select	on	[]
Select	on	[]
Select	on	[]

AFTER GRADUATE – OUTCOMES

- ☐ National Registry or State Paramedic certification on []
- ☐ Employed performing Paramedic duties as of [] at []
- ☐ Employer Survey completed as of [] (surveyed within 6 to 12 months after graduation)
- ☐ Graduate Survey completed as of [] (surveyed within 6 to 12 months after graduation)

6

Engaging in cooperative involvement with the program director;

7

Ensuring the effectiveness and quality of any Medical Director responsibilities delegated to an Associate or Assistant Medical Director;

It is recommended that the Medical Director interaction be in a variety of settings, such as lecture, laboratory, clinical, capstone field internship. Interaction may be by synchronous electronic methods.



How do you keep track of it all?

DEPARTMENT OF EMERGENCY MEDICINE

Division of Prehospital Medicine



Monroe Community College Medical Director Fourth Quarter Report

Below please find the activities during fourth quarter for 2024-25

Physician Time in the 4th quarter was spent on the following activities:

- 1) Dr. Dorsett developed, attended and provided instruction during lab and scenario days.
- 2) Dr. Dorsett developed questions for and ran a summative cognitive review for the 2024-25 cohort.
- 3) Dr. Dorsett reviewed progress of the students in the class with other faculty and helped develop remediation plans.
- 4) Drs. Dorsett and Fitzgerald attended the summative psychomotor assessment for the program as evaluators.
- 5) Dr. Dorsett reviewed and approved the curriculum, SMC, and clinical manual for the 2025-26 cohort.
- 6) Dr. Dorsett participated in classroom instruction of the 2025-26 cohort.

Please do not hesitate to contact the Division of Prehospital Medicine with any questions.

4 th Quarter June 2025 – August 2025	
Monroe Community College	58.25

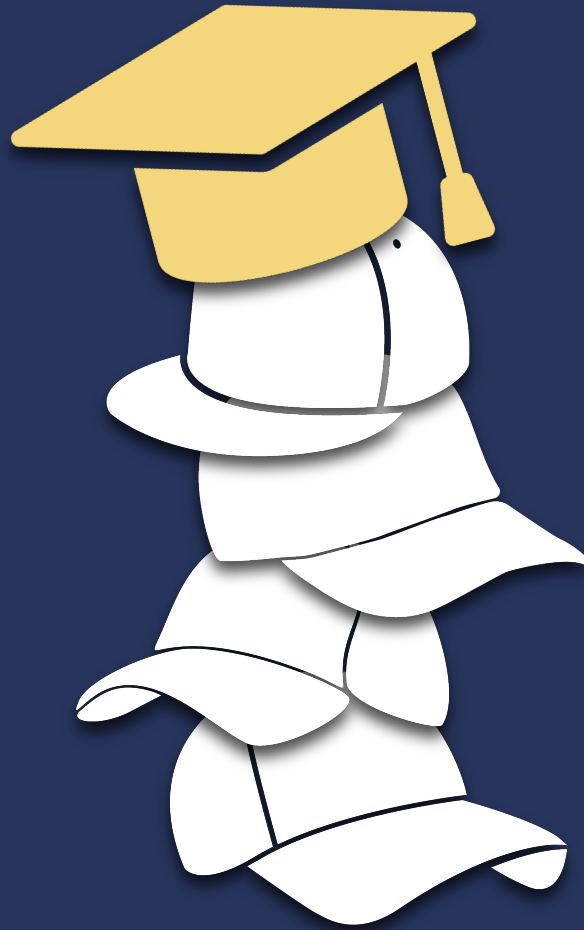
Physician	Date	Description	Hours
MD	6/12/2025	Paramedic program admission interviews	3.5
MD	6/13/2025	Simulation Scenarios	4
MD	6/19/2025	2025-26 Schedule/Curriculum review	1
MD	6/19/2025	Sim Scenario development	2
MD	6/20/2025	EBM Update - OB	0.5
MD	6/20/2025	Curriculum & SMC review – 25-26	1
MD	6/24/2025	Test Question review	0.5
MD	6/26/2025	Review/clinical judgment question writing	2
MD	6/28/2025	Review/clinical judgment question writing	5
MD	7/1/2025	Review/clinical judgment question writing	4
MD	7/2/2025	NREMT review for students	3
MD	7/3/2025	Review session answer key	0.25
MD	7/12/2025	Final psychomotor case prep	2

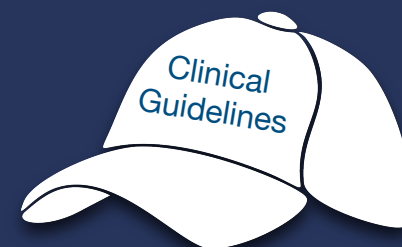
DEPARTMENT OF EMERGENCY MEDICINE

Division of Prehospital Medicine



MD	7/14/2025	EM01 Student phone calls	0.5
MD	7/16/2025	Summative psychomotor -practice session	5.5
MD	7/23/2025	Summative Psychomotor scenarios	6
EF	7/23/2025	Summative Psychomotor Scenarios	5
MD	7/31/2025	Review and provide comments on clinical manual	0.5
MD	7/31/2025	Discuss student with preceptor/review comments	0.5
MD	8/2/2025	Summative scenario development - retest	1
MD	8/4/2025	Summative psychomotor Retest	2
MD	8/5/2025	Role of Medical Director talk for EMT	1
MD	8/10/2025	Graduation	2
MD	8/24/2025	Prep for First Day of Paramedic class	1
MD	8/25/2025	First Day - Attend & Teach History of EMS	4.5





Teaching the

Unwritten

Objectives:

The Medical Director's Role in Initial EMS Education

Maia Dorsett, MD PhD FAEMS
#NAEMSP2023

By the end of this course, the learner will *commit* to the following values:



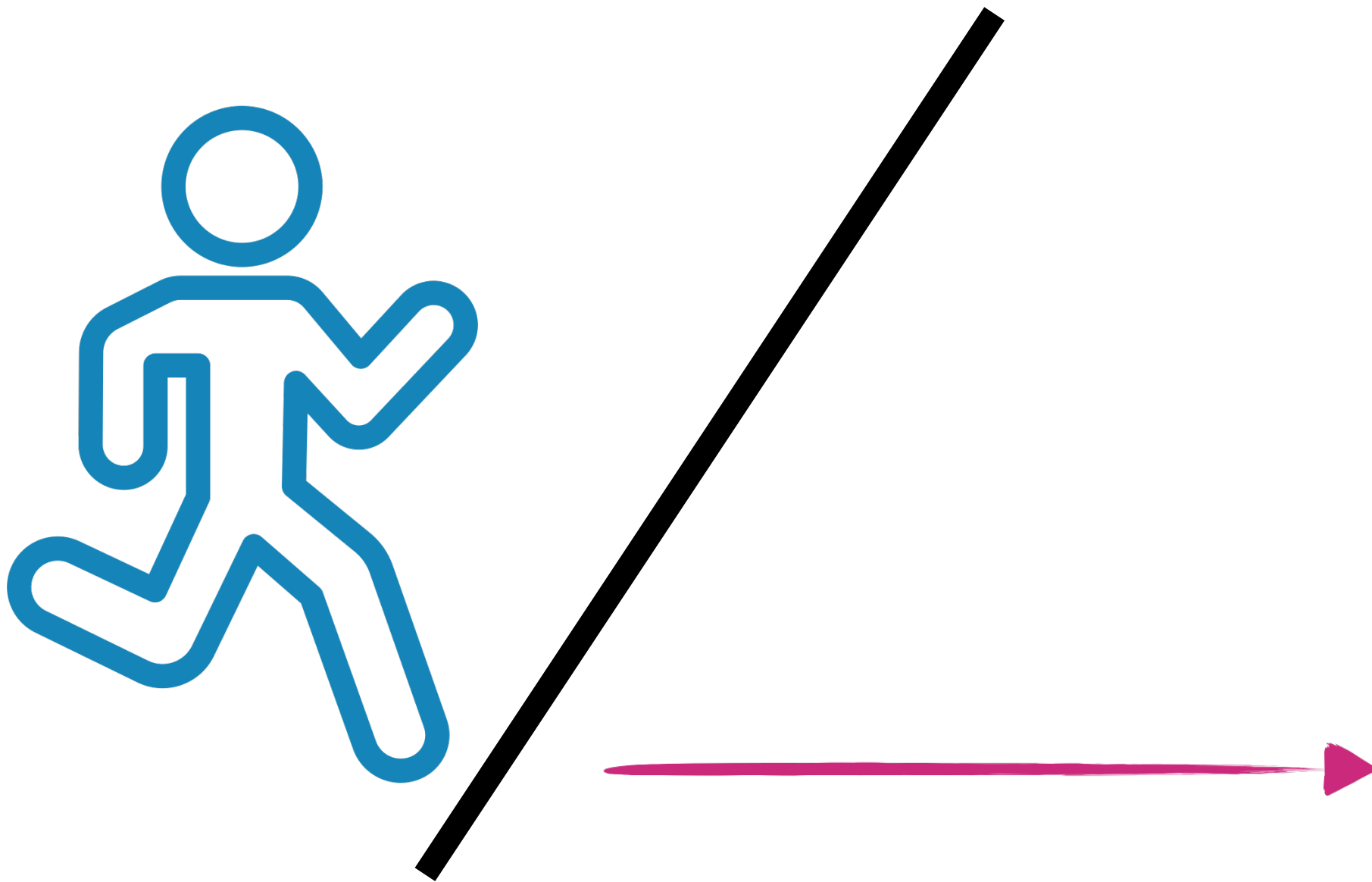
1. Excellence is the goal and we are capable of meeting it.



2. Lifelong learning is essential, and requires adaptation to changing evidence and the capacity to learn from failure.



3. Achieving excellence requires solving hard problems together.



Contact:

maidorsett@gmail.com