

December 2013

## **GMC position statement on the requirements for medical students and doctors in training gaining competence in cardiopulmonary resuscitation**

### **The aim of this statement**

- 1** We thought it would be helpful to clarify our position on cardiopulmonary resuscitation (CPR) in relation to medical education and training. This statement explains the flexibility we have built into the outcomes we require of medical students and doctors to enable them to gain the competence they need in CPR.

### **Who this will be of interest to**

- 2** We think this will be of interest to a number of related groups, but mainly disabled medical students and doctors in training and organisations delivering education and training - for example medical schools, local education and training boards/deans, hospital trusts and boards.

### **Why we are issuing a statement now**

- 3** The Medical Schools Council, which carried out a survey of all medical schools in the UK, has told us that there are currently about 10 disabled students who are expected to graduate from medical school, but who might have difficulties at the later stages of training - for example a wheelchair user who is able to direct but not perform CPR. The same issue was highlighted during our Review of Health and Disability in Medical Education and Training<sup>1</sup> in 2012.
- 4** Our view is that all disabled students and doctors in training should have a reasonable expectation that they can progress through their education and training, subject to meeting the outcomes required and having the appropriate reasonable adjustments to help them.

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<sup>1</sup> Review of Health and Disability in Medical Education and Training – GMC web page - [www.gmc-uk.org/education/12680.asp](http://www.gmc-uk.org/education/12680.asp)

- 5 But we are also conscious of the challenges which medical schools and postgraduate deans face in determining the level of support available to disabled students and doctors in training. In making decisions about the progression of a student or trainee, we recognise that they have to balance the rights and expectations of the individual against the overriding requirement to maintain standards and protect the safety of patients.
- 6 It is clear from a survey of key interests which we carried out earlier this year – and covered in paragraphs 18 to 22 below - that the regulatory requirements around CPR - which provide for a greater level of flexibility than other learning outcomes - are not always well understood.
- 7 The statement has been circulated to key interest organisations and published on our website. We would be grateful if recipients of this statement could also share it with others who will find it helpful.

### **The requirement and flexibilities for gaining competence in CPR**

- 8 We have made provisions for CPR in our education outcomes and standards which provide some flexibility for disabled students in undergraduate medical education and doctors in Foundation training.
- 9 The flexibility enables students and doctors in training to either undertake CPR or - if they are not able to do so as a result of their disability – direct others to do so. This flexibility does not apply to other learning outcomes (see our [statement](#) (pdf)).

#### *Undergraduate education*

- 10 In *Tomorrow's Doctors* 2009<sup>2</sup> – page 22, paragraph 16 – we require as an outcome that a student should be able to:

*'Provide cardio-pulmonary resuscitation or direct other team members to carry out resuscitation.'*

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<sup>2</sup> *Tomorrows Doctors*, 2009 – General Medical Council - [www.gmc-uk.org/static/documents/content/GMC TD 09 1.11.11.pdf](http://www.gmc-uk.org/static/documents/content/GMC_TD_09_1.11.11.pdf)

## *Foundation training*

**11** We have included a similar flexibility in the *Trainee Doctor*<sup>3</sup> for provisionally registered Foundation year-1 doctors (F1). Section 36(d), page 46 says:

*'The doctor must demonstrate that they are recognising and managing acutely ill patients under supervision. This includes showing that they are able to **manage** a variety of situations where a patient requires resuscitation.'*

**12** We also approve the Foundation Programme Curriculum<sup>4</sup> developed by the Academy of Medical Royal Colleges. This includes the outcomes for Foundation Years 1 and 2 in respect of resuscitation.

**13** The requirement is that F1 doctors should be 'trained in immediate life support (ILS or equivalent) and paediatric life support if working with children'.<sup>5</sup>

**14** Foundation year 2 doctors are expected to be 'trained in advanced life support (ALS) and initiate ALS resuscitation and lead the team where necessary'.

**15** The ILS and ALS are the standardised national course teaching guidelines produced by the Resuscitation Council (UK) for healthcare professionals in the UK.

**16** If a doctor in training cannot physically perform tasks included in the ILS or ALS **as a result of a disability**, the Resuscitation Council allows them to direct others to undertake resuscitation and complete that element of training. So the

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<sup>3</sup> The Trainee Doctor – The General Medical Council – [www.gmc-uk.org/Trainee\\_Doctor.pdf\\_39274940.pdf](http://www.gmc-uk.org/Trainee_Doctor.pdf_39274940.pdf)

<sup>4</sup> The Foundation Programme Curriculum –The UK Foundation Programme Office - [www.foundationprogramme.nhs.uk/pages/home/curriculum-and-assessment/curriculum2012](http://www.foundationprogramme.nhs.uk/pages/home/curriculum-and-assessment/curriculum2012)

<sup>5</sup> Where a Local Education and Training Board/Deanery considers that a provisionally registered F1 doctor in a training programme would be disadvantaged unfairly by their disability, they can propose to the GMC adjustments which would help enable them to meet the required outcomes in the *Trainee Doctor*. There is provision in Section 10A 2(f) of the Medical Act for the GMC to determine the arrangements needed to support this. We would of course consider each application on a case-by-case basis. However, in the first instance, we would normally expect those organising education and training to make adjustments around CPR in line with the flexibility outlined in paragraph 16, without the need to involve the GMC.

approach taken by the Resuscitation Council is in line with *Tomorrow's Doctors* and *The Trainee Doctor*, in that a doctor in training who has a relevant physical disability can achieve the ILS/ALS or equivalent standard by directing others to undertake resuscitation rather than undertaking it personally.

### *Specialty training*

- 17** The requirement for CPR competence in specialty training programmes will depend on the requirements of the individual discipline. There may not necessarily be the same flexibility as exists in undergraduate or Foundation training.

### **What key interest organisations have told us**

- 18** In parallel with the survey undertaken by the Medical Schools Council, we surveyed key interest organisations including Health Education England, the Academy of Medical Royal Colleges, COPMeD, NHS Employers, NHS Education for Scotland, the Northern Ireland Medical and Dental Training Agency and the BMA. It was clear from the responses that the current regulatory requirements for CPR are not well understood and that a statement would be helpful to clarify our regulatory position.

### *Balancing the expectations of students/doctors with the needs of the service*

- 19** We asked whether the flexibility to direct or manage CPR achieves an appropriate balance between the needs and legitimate expectations of disabled students and trainees, on the one hand, and, on the other, the needs of the service and the safety of patients?
- 20** There was general support for the flexibility we have built into education outcomes to undertake or direct CPR. However, some felt that it would be difficult for disabled students to achieve the skills of directing others to perform CPR. Others recognised the challenges which the flexibility may pose to employers given that undertaking and directing others are different levels of competence.
- 21** We also heard concerns about the challenges which delivering CPR may pose for service, particularly in General Practice and A&E environments and during night shifts.

### *Mitigating the challenges*

- 22** Key interests made several suggestions for how the risks to safe, effective service provision in the context of CPR might be mitigated:

- More effective transfer of information to support the transition of disabled students into the Foundation Programme.
- More effective transfer of information to support the movements of disabled doctors in training between rotations.
- Better career guidance to help manage expectations of disabled students and doctors in training from an early stage.
- Sharing of monitoring data on the number of disabled students and doctors in training who have difficulties performing CPR so the issue can be better understood.

### **How CPR will be taken into account in our future work**

**23** We hope this statement has helped both clarify the position in respect to CPR and provide ideas for further reflection on the appropriate support which can be made available to students and trainees,

#### *Monitoring progress*

**24** We will continue to monitor how CPR is being delivered through our quality assurance process.

**25** We will be particularly interested to know how the transfer of information process is supporting disabled students and doctors in training. The transition from medical school to foundation training is crucial for all new doctors. For those with health or disability issues it is particularly important that transition is planned effectively and that information the receiving organisations needs to have is shared in good time. Otherwise, the relevant Foundation School and NHS employing organisation will not be in a position to ensure a safe and appropriate working environment for the disabled new doctor.

#### *Review of the practical procedures we require*

**26** In 2015, we will be reviewing all of the practical procedures required in *Tomorrow's Doctors, 2009* and the *Trainee Doctor* to determine whether they remain fit for purpose. The review will take into account the requirements for CPR and what our quality assurance data have told us.