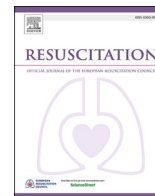




Contents lists available at ScienceDirect

Resuscitation Plus

journal homepage: www.elsevier.com/locate/resuscitation-plus

Letter to the Editor

Mirror, mirror, on the wall, who's the fairest of them all?



ARTICLE INFO

Keywords:

Cardiopulmonary resuscitation

Basic Life Support

Education

Diversity, Equity

Inclusion

CPR Training

Letter to the Editor

We would like to congratulate *Andreotti et al.*¹ on their article regarding the perspectives and perceptions of children and teachers in improving Basic Life Support (BLS) training. The study provides valuable insights into how BLS training for schoolchildren can be enhanced by increasing engagement, integrating theory with practice, involving teachers in course design, and fostering a supportive learning environment. These changes could lead to more effective training outcomes and better preparedness among young individuals in emergency situations. However, we are observing a mirror reflection that depends on the angle, lighting, and personal preferences of the beholder (cultural biases, language, values, and disabilities). A single model does not fit all conditions, but what are we really doing to train neurodivergent schoolchildren who were excluded from clinical studies related to BLS? In a world that advocates for inclusion and the reduction of gender, racial, and intellectual capacity inequalities, programs to promote and implement these ideals are necessary (Fig. 1). The opportunity for neurodivergent children to acquire psychomotor skills and knowledge to activate the chain of survival should be discussed and implemented in our society, beginning with researchers in the science of resuscitation. Especially in developing countries, access to BLS training is limited and exclusionary for the majority of children.

Efforts from international initiatives such as ILCOR², ERC³, and

AHA⁴ are cornerstone and valuable to disseminate knowledge and guide public policy to ensure equitable health for all. A scoping review conducted by *Berlanga-Macías et al.*⁵ focused primarily on adults with diverse disabilities, including hearing and visual impairments, Down syndrome, and wheelchair use. The study found that, with minor modifications, BLS training can be effectively adapted for these populations. However, there remains a lack of consensus on the specific adjustments needed to ensure that BLS programs are fully inclusive and effective for each group. An example of BLS training in a population of children and adolescents with hearing loss is the study coordinated by *Galindo Neto et al.*⁶ which demonstrated evidence of effectiveness in that population. However, when we analyzed data from the literature on children with autism spectrum disorder and Down syndrome, we observed a lack of evidence.

Perhaps, adapting the training requires personalized techniques such as the use of serious games⁷, tailored instructional videos, and training facilitators for this population. How can we change this reality globally? Through collaborative and adaptive initiatives, overcoming barriers such as prejudice and teachers' aversion to teaching BLS, and by building a personalized curriculum. We are not proposing to create special programs or new methodologies but to adapt existing courses and include these participants in regular training. The question then is not who is fairer, the specialists or the children, but what we can learn from this reflection of our society.

<https://doi.org/10.1016/j.resplu.2024.100812>

Received 8 October 2024; Received in revised form 18 October 2024; Accepted 21 October 2024

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Fig. 1. Childrens Save Hearts initiative diversity and inclusion.

CRediT authorship contribution statement

Uri Adrian Prync Flato: Writing – original draft, Visualization, Supervision, Project administration, Conceptualization. **Ricardo Ferreira Mendes de Oliveira:** Writing – review & editing, Visualization. **Lucas Kallas-Silva:** Writing – review & editing, Visualization. **Maria Fernanda Dias Azevedo:** Writing – review & editing, Visualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Uri Adrian Prync Flato^{a,b,*}, Ricardo Ferreira Mendes de Oliveira^b,
Lucas Kallas-Silva^b, Maria Fernanda Dias Azevedo^b
^a Hospital Israelita Albert Einstein, São Paulo, SP, Brazil
^b Faculdade Israelita de Ciências em Saúde Albert Einstein, São Paulo, SP, Brazil

* Corresponding author at: Hospital Israelita Albert Einstein, Av. Albert Einstein, 627/701 - Morumbi, São Paulo 05652-900, Brazil.
E-mail addresses: uriflato@einstein.br, uriflato@gmail.com (U.A.P. Flato).