saúde EM DEBATE

ORIGINAL ARTICLE

‘Suicide is not a clinical case topic!’: On taboos, particularities, and gaps in pediatric medical education

‘Suicídio não é tema de sessão clínica!’: sobre tabus, peculiaridades e lacunas na formação médica pediátrica

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ABSTRACT The epidemiological transition in Brazil has led to adaptations in the care of children and adolescents. This New Pediatrics identifies violence, chronic and complex conditions, and mental health as central issues, with suicidal behavior standing out due to its clinical and epidemiological impact. As critical components of medical education, Pediatric Medical Residency Programs serve as privileged settings for understanding how this specialty has been organized and how it operates clinically. This study aimed to understand pediatric residents’ perceptions and knowledge regarding suicidal behavior in childhood and adolescence. A social research study was conducted using a qualitative approach through the Focus Group (FG) technique, involving 44 residents from five Pediatric Medical Residency Programs in Rio de Janeiro. Content analysis, following a thematic approach, revealed three main meaning units that emerged from discussions across the five FGs: The taboo of suicide; Peculiarities of pediatric care: idealizations and conflicts; and Training gaps within Pediatric Medical Residency Programs. An integrated and appropriate approach to suicidal behavior by pediatricians requires the reorganization of these programs, facilitating the overcoming of taboos and promoting reflection on the conflicts that shape this specialty.

KEYWORDS Suicide. Self-injurious behavior. Pediatrics. Internship and residency. Focus Groups.

RESUMO *A transição epidemiológica no Brasil vem provocando adaptações no cuidado de crianças e adolescentes. Essa Nova Pediatria tem a violência, as condições crônicas e complexas e a saúde mental como questões importantes, com destaque para o comportamento suicida por seu impacto clínico-epidemiológico. Sendo críticos para a formação médica, os Programas de Residência Médica (PRM) em pediatria são espaços privilegiados para o entendimento de como essa especialidade tem se organizado e atuado clinicamente. Assim, objetivou-se compreender a percepção e seu conhecimento dos médicos residentes em pediatria sobre o comportamento suicida na infância e na adolescência. Foi realizada pesquisa social, utilizado o método qualitativo, por meio da técnica de Grupos Focais (GF), a partir da qual participaram 44 médicos residentes de cinco PRM no Rio de Janeiro. A partir da análise de conteúdo, modalidade temática, três unidades de sentido se destacaram no debate provocado em cinco GF: O tabu do suicídio; Peculiaridades da assistência pediátrica: idealizações e conflitos; Lacunas formativas dos PRM em pediatria. Uma abordagem integral e adequada do comportamento suicida pelos pediatras demanda uma reorganização dos PRM, facilitando a superação de tabus e permitindo reflexões sobre os conflitos que fundam essa especialidade.*

PALAVRAS-CHAVE *Suicídio. Comportamento autodestrutivo. Pediatria. Residência médica. Grupos Focais.*

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Introduction

Pediatrics, as a branch of medicine dedicated to the care of children and adolescents, has been strained by contemporary healthcare and cultural demands[1-3]. These demands are driven by the epidemiological transition, leading to higher rates of congenital conditions, neoplasms, and external causes as important factors associated with pediatric morbidity and mortality[4,5]. Thus, the existence of a New Pediatrics is considered, in which the management of chronic and complex health conditions, the incidence of violent events, and the prevalence of mental disorders stand out for healthcare planning, practice, and professional training[5-7].

Medical residency is considered the most comprehensive model of medical specialization, its essence being the dyad of 'teaching and service'[8,9]. It constitutes a pedagogical proposal according to which practical and supervised training in health units of varying complexity should allow and organize the acquisition of skills and abilities. Medical Residency Programs (PRM), therefore, are the preferred locations for continuing undergraduate studies, receiving a plurality of young people, most of whom have little experience in professional practice[10].

From this perspective, the PRMs have the challenging mission of providing Resident Physicians (MR) with the competencies to address new clinical, psychosocial, and epidemiological demands[11,12]. With this objective, and seeking alignment with the reality of international pediatrics[13,14], the Pediatric Residency Programs were extended to three years in 2019. Among these demands, suicidal behavior in childhood and adolescence stands out due to its magnitude, sensitivity, and formative urgency, a phenomenon that, in the last decade, has mobilized families, different sectors of society, and the pediatric profession in the country[15,16]. This concern, however, has not reversed the theoretical and clinical inability of Pediatric MR regarding this topic[14].

Suicidal behavior is understood as a continuum of self-harm that involves ideation, threats, attempts, and completed suicide[16,17]. As a fatal outcome of this spectrum, suicide constitutes one of the most critical events for the health field, a challenge to its understanding and approach[14]. Data from the Ministry of Health (MS) published in 2024[18] indicate a trend of increasing mortality from suicide in Brazil, mainly after 2014. In 2021, suicide was the 11th leading cause of death among the population aged 5 to 14 and the 3rd among those aged 15 to 19. Although about 77% of suicides in the country are men, among women, the peak incidence is in adolescence. The occurrence of self-inflicted injuries, grouping suicide attempts and non-suicidal self-harm reported, also stood out in the MS document[18]. Of the total notifications, 23% occurred in the second half of adolescence (15 to 19 years), and 11.5% in the pediatric group aged 5 to 14 years[18].

Thus, investigating how suicidal behavior in childhood and, especially, in adolescence has been understood by PRMs is relevant as a strategy to understand and improve the approach to this phenomenon in training and practice. This study did not focus on suicidal behavior itself, but on the dialogical relationship of MRs with this theme and the participation of their PRMs in this process. Following Elias[19] in his defense that the study of death is a dedication to the study of life, the objective of this study was to understand and analyze the perception and knowledge of pediatric medical residents about suicidal behavior in childhood and adolescence.

Material and methods

This article was produced from the dissertation 'Perception and knowledge of resident physicians in pediatrics in Rio de Janeiro about suicidal behavior in childhood and adolescence'[14]. The ideas presented reflect a second look at the research, whose theme persists as a challenge to public health, recognizing that

one interpretation is not the last word in the study of an object[20].

A social research study was conducted using a qualitative method, employing the Focus Group (FG) technique, fostering empathetic interaction between researchers and participants[21,22]. It was assumed that an interactional approach would be important for a better understanding of the facts and human relationships involving thoughts, feelings, attitudes, and practices[20-22].

Given the 24 PRMs accredited in 2018 in the Rio de Janeiro Metropolitan Region, the selection of units considered: location within the urban area (seeking to broaden patient profiles), the presence or absence of emergency services (to assess the influence of these sectors on the training of MRs), and formal or informal affiliation with teaching and research institutions (in order to observe whether the academic structure interferes with this training). First-year (R1) and second-year (R2) residents were recruited to allow for comparison between participants with different training periods. Thus, five PRMs in pediatrics constituted the research field; all located in public units and linked to the Unified Health System (SUS).

An FG was conducted for each PRM, on dates and at locations chosen by the respective coordinators. The description of the five FGs and PRMs is presented in *box 1*. Data collection took place during the FGs (May 15, 2018 to July 3, 2018), involving 44 medical residents (27 first-year residents and 17 second-year residents). The activities required the following approvals: institutional approval from the hospital hosting the PRM; approval from the coordination of each PRM; and approval from each participant (through the Informed Consent Form).

Box 1. Characterization (2018) of the Focus Groups and hospital units of the Medical Residency Programs in Pediatrics participating in the research.

Descriptors	PRM/FG 1	PRM/FG 2	PRM/FG 3	PRM/FG 4	PRM/FG 5
Hospital management model	Federal hospital	State hospital	Federal hospital	Federal University Hospital	State University Hospital
Urban location in the Rio de Janeiro Metropolitan Region	North Zone of the municipality of Rio de Janeiro	Baixada Fluminense	South Zone of the municipality of Rio de Janeiro	East Fluminense	North Zone of the municipality of Rio de Janeiro
Affiliation with Educational/Research Institutions	No	No	Yes	Yes	Yes
Presence of a Pediatric Emergency Service	Yes	Yes	No	Yes	No
Number of MR participants in the FG	12	7	13	5	7

Source: Own elaboration adapted from Silva Filho[14].

PRM: Medical Residency Program; FG: Focus Group; MR: Resident Physicians.

Three researchers participated in each focus group: the moderator, who led the activity, and two rapporteurs (for logistical support). The discussions that took place in the meetings were audio-recorded and subsequently transcribed. Each focus group began with a 'warm-up phase'[22], when researchers and participants were introduced, made

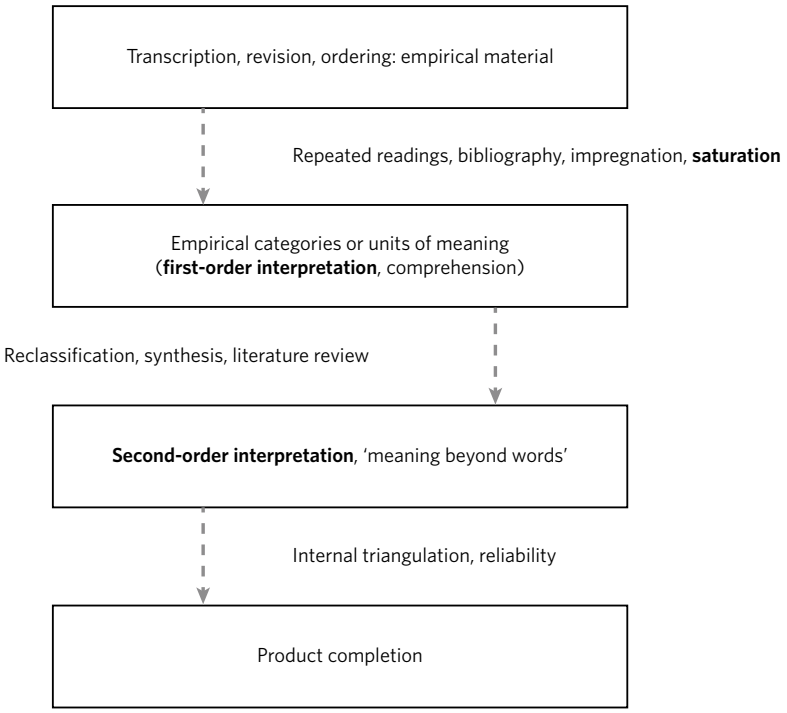
agreements for the meeting, and were asked to answer a sociodemographic questionnaire and the informed consent form. The questionnaire contained questions about suicidal behavior, medical training, and professional practice, serving as a thematic introduction. In the 'reflective phase' of the meeting[22], the moderator provoked dialogue, creatively and sensitively using questions from a script, stimulating the participants' involvement.

As 'speaking beings'[23], the different voices of the pediatric MRs were heard from three perspectives on suicidal behavior in childhood and adolescence: 'What is it?'; 'The possibility of affectation'; 'Preparation for a pediatric approach'. It was understood that the focus groups, by allowing debate and synergy among the participants, went beyond the configuration of a collective interview[24], becoming a comprehensive instrument for addressing consensuses, dissensions and specificities[21,22] on the perception, experiences and knowledge about suicidal behavior.

In this research, perception was understood as the apprehension of the world through the senses, promoting personal experiences. Lived experiences are reflections of the individual over everyday life[25]. Experiences and lived experiences constitute common sense, which guides each subject in the various actions and situations of life, through values, beliefs, and ways of thinking, feeling, relating, and acting[25]. Knowledge can be both an expression of common sense and formatted and authorized by an established and recognized by the PRM. The intention was not to value knowledge as a single or dominant body of knowledge, but as it was structured and disseminated in the normative institutions of pediatrics.

The analytical step employed is outlined in *figure 1*. The analyzed corpus was organized with the transcripts of each focus group, the written records, and the researchers' initial impressions. Then, the analysis of the collected content was carried out, using thematic modality[21,26], which led to the recognition of seven units of meaning or first-order interpretations. The interpretative and reclassification effort, supported by repeated readings and bibliographic review, allowed for their synthesis into three second-order categories, whose meaning was already apparent from the participants' statements: 'The taboo of suicide'; 'Peculiarity of pediatric care: idealizations and conflicts'; and 'Formative gaps in pediatric medical residency programs'.

Figure 1. Synthetic scheme of the analytical stage employed in the research



Source: Own elaboration adapted from Minayo[21].

Other ethical issues deserve highlighting; after each focus group, an academic activity was conducted to discuss the topic, with feedback provided to the participants. None of the 44 participants reported emotional distress resulting from the research activities, even after the provision of timely support after the meetings. On the contrary, according to the residents, the focus groups generated several opportunities: individual reflection; acquisition of technical knowledge; self-criticism about their own lack of knowledge in the area; and closer relationships with colleagues. According to Minayo[21], the method is the soul of the content in research; thus, the chosen technique was a good trigger for reflection and interaction. In this way, even before the data analysis, the importance and potential of discussions on this delicate topic became evident, having been recognized by the medical residents as a strategy for capacity building and emotional support.

The study received initial approval from the Research Ethics Committee (CEP) of the Fernandes Figueira National Institute of Women's, Children's and Adolescents' Health (Certificate of Presentation for Ethical Review – CAAE No. 833111518.0.00005269 and Opinion No. 2,533,685).

Results and discussion

This section presents a concise description and discussion of the results.

Descriptive summary

The sociodemographic profile of the 44 MRs who participated in the five focus groups is presented in *table 1*. The majority were young (mean and median age of 27 years), female, in their first year of residency, had a religion, and worked in other hospitals in addition to their medical residency.

Table 1. Profile of pediatric resident physicians participating in the research.

FG / number of participants	Year of medical residency		Gender		Work		Religion	
	R1	R2	M	F	Yes	No	Yes	No
FG 1 = 12	6	6	2	10	9	3	8	4
FG 2 = 7	4	3	2	5	7	0	6	1
FG 3 = 13	10	3	2	11	8	5	10	3
FG 4 = 5	3	2	2	5	5	0	5	0
FG 5 = 7	4	3	1	6	6	1	6	1
Total = 44 (%)	**27 (61.3)**	**17 (38.7)**	**9 (20.5)**	**35 (79.5)**	**35 (79.5)**	**9 (20.5)**	**35 (79.5)**	**9 (20.5)**

Source: Own elaboration adapted from Silva Filho[14].

FG: Focus Group; R1: First-year medical resident; R2: Second-year medical resident; M: Male; F: Female.

The questionnaire used allowed for an understanding of the educational and professional performance landscape of these physicians, as shown in *table 2*. This landscape served as the basis for one of the analysis categories, in which curricular gaps regarding suicidal behavior in childhood and adolescence in pediatric training were identified, representing the first response of the research. Initially constructed from the questionnaire data, this unit of meaning was better understood in the discursive analysis of the focus groups, when it was shown to be synergistically constituted by the other two categories, as illustrated in *figure 2*.

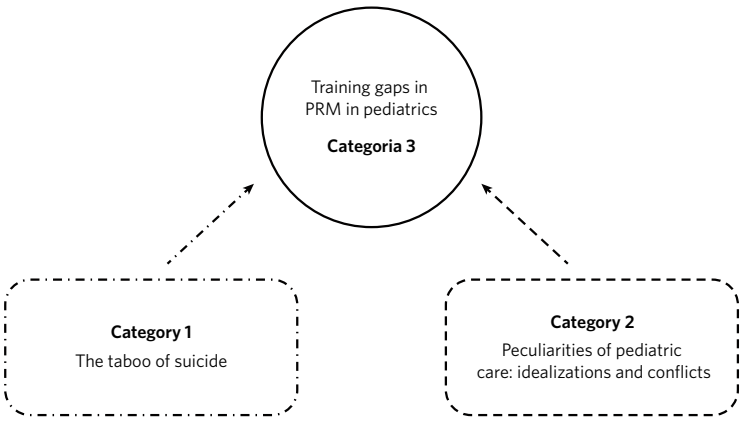
Table 2. Medical and pediatric training and professional activities of pediatric resident physicians participating in the research.

	FG 1 (12)	FG 2 (7)	FG 3 (13)	FG 4 (5)	FG 5 (7)	Total (%)
Lecture/discussion during medical school about CS	7	6	7	4	5	29 (65.9)
Lecture/discussion in the PRM about CS	0	0	1	0	0	1 (2.2)
Question about CS in the PRM selection process.	1	0	2	0	0	3 (6.8)
Lecture/presentation at scientific events	5	1	3	4	6	19 (43.1)
Pediatric care for cases of CS	4	3	4	2	6	19 (43.1)

Source: Own elaboration adapted from Silva Filho[14].

GF: Focus Group; CS: Suicidal Behavior; PRM: Medical Residency Program.

Figure 2. Graphic scheme of the research analysis categories



Source: Own elaboration adapted from Silva Filho[14].

Three aspects raised in the responses from the MRs pointed to the recognition of these gaps: 1) adult-centered medical training; 2) PRMs' scenarios disconnected from professional practice; 3) the fragility of supervision on suicidal behavior by PRMs. As shown in *table 2*, the difference between the number of MRs who indicated having participated in medical lectures/discussions on suicidal behavior during their undergraduate studies and during their residency programs is striking (29 versus 1). Although epidemiological data suggest that self-inflicted violence is relevant to the child and adolescent population[15,16,18], pediatric training has not incorporated its importance nor discussed its specificities, with a weak and adult-centric approach prevailing.

> *When I rotated through psychiatry, the subject was covered in college, but it wasn't geared towards children; nobody ever said, 'Oh, suicide in pediatrics!' That's something that's very, very far removed from our daily lives.* (R2, FG3).

In 2018, almost half of the participants reported having provided professional care to cases of attempted suicide in adolescents. The instrument did not specify where these interventions took place, but it allowed us to understand that there was no supervision in the PRMs regarding such cases. This made it possible to infer the existence of weaknesses in supervision when these cases presented themselves in the PRM's care units and that the internship settings did not necessarily reflect the dynamics found in work outside the PRM. It is recognized that the curriculum of a PRM should be able to encompass the entire dimension of pediatric care, especially in relation to the most prevalent conditions[1,2,11]. It is also considered that work in spaces outside the PRM should not serve to fill training gaps[9,10].

The debate with and among the MRs indicated no discursive difference between R1s and R2s in the same PRM, in any of the five residencies studied, which corroborated the partial inability of the PRMs as formal teaching spaces, therefore, the length of residency was not an important variable for the acquisition of knowledge and skills about suicidal behavior. The statements evidenced personal experiences on the subject, suggesting an overlap between what was recognized in the research as 'perception' and as 'knowledge'[14]. In the absence of formal teaching and supervision on suicidal behavior, what was experienced in the private sphere and in work environments became the greatest influence and source

of reflection for the professional practice indicated in the FG.

Unlike what was predicted in the preliminary fieldwork phase, the presence of pediatric emergency services – and their potential exposure to cases of suicidal ideation and attempts – did not result in a difference in the approach to suicidal behavior among the PRMs. Similarly, despite the self-declaration of religion by almost 80% of the MRs, terms and concepts of no belief stood out in the discussions, and were not the subject of analysis.

The very discreet presence of questions about suicide in medical residency selection processes and the small participation of medical residents in lectures on the subject at scientific events (*table 2*) were an indication that added to a difficulty that seemed, therefore, to extend beyond the boundaries of medical residency programs. In this context, it was considered whether the disregard for this topic should not be a characteristic not only of medical residents and their supervisors, but also of pediatrics as a specialty.

"Which grief would be easier to live through?" – The taboo of suicide

This question was posed by a first-year resident (R1) in the second focus group and summarized the anxieties reported by the MRs as individuals and as professionals. Life, death, grief, and suicide were prominent themes in this inquiry, correlating with the taboos that permeated their discourse.

Suicide was interpreted by the participants as a death "*that goes against natural law*" (R1, FG2), being "*different from others, since the normal course of life is to die from some pathology or accident*" (R1, FG4). It was mentioned that suicide is the death that most problematizes life and, therefore, the one that most affects medical practice. The discomfort that silenced and hindered a technical approach to the topic was noticeable, with common sense and taboos prevailing.

The moderator's provocations initially elicited accounts and narratives from family and acquaintances, filled with value judgments and personal affect. This discomfort was also perceived through the consensual recognition of the universality of suicide, such that it *"is real, it can happen to anyone, you just have to be alive"* (R1, FG1). This corroborates Durkheim's idea that suicide is a human and universal fact, even if singular, with various suicides existing[27].

Discomfort could also be recognized as a reflection on the burden of suffering carried by individuals who commit suicide, as argued by Shneidman[28]. In establishing the field of suicidology, the psychologist argued that the suicidal act should be understood as a multidimensional distress suffered by a vulnerable individual who conceives of their death as the only solution, at a moment of maximum pain, disturbance, and pressure[28,29].

In the silences and discomforts, the voices that prevailed were marked by lived experiences and everyday life. Little was said that indicated professional or academic training on the subject. In the debates, it was possible to identify, in parallel to the issue of suicide, that it was necessary to validate and deepen the reflection on the event of 'death', a subject rarely addressed in pediatric studies and practices, even when resulting from organic and natural causes.

Thus, the taboo of death precedes the taboo of suicide, making it impossible to deal with suicide without first enduring and confronting death ethically and professionally, and not as an enemy to be fought[19,30]. The following statement exposed this reality: "*We fight so hard for life, we are used as doctors to always saving lives, and then you deal with someone who wants to take their own life*" (R2, FG1). This perspective was defended by Dias[31] in his proposition of a 'double taboo', in recognition of the medical fragility in professionally enduring death, even knowing of its existence.

The concept of double taboo was strained when pediatric death was put into perspective.

The taboo of death and suicide becomes even more complex when children and adolescents are perceived as 'both victims and perpetrators' in this painful scenario. Taboo of death – taboo of suicide – taboo of suicide in childhood and adolescence: the triple taboo[15].

As Pereira[32] discusses, the birth of national pediatrics as a medical specialty was linked, socially and historically, to the commotion and the fight against infant mortality. The pediatric ethos – built and updated in the PRM – continues to be marked by its original traits: protecting life, freeing families from the stigma of mortality and leading their offspring to a destiny of health, robustness and vitality[32].

Thus, practicing pediatric care, characterized as a hope for the future, seemed incompatible with suicidal behavior in children and adolescents: "*I can't imagine what might go through a child's mind to attempt suicide*" (R2, FG2). This stance crystallizes the position of suicide as a subversion of Western medical culture[30], permeating pediatric training.

A question has arisen in the field: what deaths, what grief, and what taboos have PRMs chosen to confront? In 2018, research results indicated that it was not the self-inflicted deaths, results that still reflect what is currently experienced by PRMs. If physical, mental, and social well-being is added to the definition of health proposed by the World Health Organization[33], it is pertinent that all forms of death and illness be validated. Investing in the development of skills and reflections on death, violence, and emotional suffering is an urgent strategy, as are reliable professional activities (Entrsustable Professional Activities – EPA) for the training of professionals capable of addressing and preventing pediatric suicidal behavior[1,11]. It is therefore necessary to situate painful and violent events within the understanding of morbidity and mortality, considering that they occur mainly at the end of childhood and during adolescence; just as it is necessary to invest in strengthening the new proposal for PRMs in pediatrics[13].

"Oh! How I miss the dawn of my life, my beloved childhood!" – Peculiarities of pediatric care: idealizations and conflicts

In a testimony about how he chose and has experienced the pediatric specialty, an R2 (FG 4) recited some verses from 'My Eight Years'[34], illustrating this analytical category that addressed the romantic and idealized ideal of this specialty.

According to Ariès[35], social awareness of childhood in Western societies was constructed through its romanticization, starting in the 17th century. Two sentiments about this phase were important: pampering (in which the naiveté, gentleness, and grace of children became elements of distraction and relaxation for adults) and psychological interest and moral concern about infants.

This second sentiment, influenced by the religious movement and the Modern State, promoted proposals on discipline, morality, hygiene, and health, treating children as divine and 'voiceless' creatures[35,36]. The emergence of pediatrics remained rooted in these guidelines and in the fight against mortality, immorality, and deviance, so that pediatricians are socially validated as the guardians of infants, authorized to speak publicly and scientifically in favor of their protection[32,36]. This validation, however, often silences the subject who receives care.

The question then arose as to whether the ideal of what it means to be a pediatrician has allowed for a perspective that values the subjectivity of children and adolescents and understands the existence of their emotional suffering in certain circumstances. Wouldn't the angelic representation of this population preclude addressing socially painful topics, more averse to the role of a pediatrician, such as suicidal behavior?

It was possible to identify two conflicts: care-related, experienced by professionals whose experience does not facilitate the management of the frequent morbidity and

mortality conditions addressed in this study; and generational, experienced by pediatricians who tend to ally themselves with families, reproducing parental discourses. Castellano[36] addressed this topic by illustrating that the interaction in pediatric consultations passes through the voice of adults and the body of the child, reiterating the character of enfants; in a silencing of narratives that should be brought to the consultations and reveal concerns, suffering and violence.

Not listening to children and adolescents themselves – subjects of rights under the Child and Adolescent Statute[37] – prevents understanding their doubts and suffering, which are not always physically manifested. Here, not only children are relegated to the position of voiceless beings, but also adolescents. Although potentially capable of expressing their feelings, the estrangement of pediatrics towards adolescents has made it difficult for this pediatric subgroup to receive comprehensive care[38].

The challenges and conflicts expected in adolescence are presented as barriers to pediatric practice, whose sensitivity does not reach these individuals, emphasizing their proximity to adult life and updating professional generational conflicts[38,39], as exemplified: "*In adolescence everything is very intense! When the adolescent feels bad, he feels like the worst thing in the world. He doesn't know anything about life yet*" (R1, FG1). These conflicts can materialize in different conservative postures in the clinical setting, such as a lack of knowledge of new languages and media, and indifference to expressions of gender, sexuality and culture, revealing a clinical training disconnected from reality[1,38].

Organizational impasses in healthcare units also amplify this distance between pediatricians and adolescents, marking a non-place of care, even when the clinical management of conditions frequently found in adolescents is considered a 'reliable professional activity' for pediatricians[1]. Thus, greater difficulty arises in understanding the subjectivity and in addressing the 'suicidality' of this group, in which there is a clear increase in suicide attempts and completed suicides[18].

It is possible that, for the MR who spontaneously evoked romantic verses during the encounter, childhood was the best phase of his life. However, the problem was acknowledged when this romantic ideal continues to underpin pediatric practice, hindering a more in-depth and complex education.

"Because suicide is not a topic for clinical sessions!" – Training gaps for pediatric medical residents.

The existence of curricular gaps regarding suicidal behavior in pediatric medical residency programs was present in the assumptions of this study and was validated in the field. Given its relevance in clinical and epidemiological contexts, why hasn't it become a topic of clinical sessions? The emphatic statement of a second-year resident (FG5) drew attention to this gap and confirmed to the researchers that medical residents and their medical residency programs acknowledged these deficiencies.

Technical ignorance was evident at the beginning of the meetings, when the MRs genuinely expressed their doubts and difficulty in studying the subject, as expressed by an R1 (FG4): *"I, at least, don't even know where to begin studying this subjective thing like this"*. This lack of knowledge reveals, in a way, a medical ambiguity, as indicated by Marquetti40, when he says that there is a declaration of responsibility for life, but a denial of some types of death. *"It's not something we give importance to in our training"* (R2, FG3) was an argument that expressed indifference towards the topic, even while being aware of its impact.

In the absence of curricular importance given to this subject, the private sector organizes healthcare practice. The private sector, therefore, goes beyond the complementary role of teaching and service in PRMs, becoming a protagonist, as a resident pointed out:

> *That's why there needs to be more discussion and training: you level everyone down to the basics. It won't just depend on empathy, what you've experienced, and contact with it outside the home.* (R2, FG5).

Medical residency programs in pediatrics failed to propose training that overcame their shortcomings, naiveté, prejudices, and taboos, reinforcing this medical ambiguity.

The complexity of the topic was highlighted by the groups, in a critical understanding that "*It doesn't only involve the medical issue, it involves the psychological issue, the emotional issue, not only of the patient, but also of the doctor himself in dealing with it*" (R1, FG5). The solution, however, tends to be greater detachment, and not the acquisition of skills. In the early stages of the Brazilian medical discussion on suicide in youth, Cassorla pointed out some conflicts experienced in medical life, comparing them to those experienced in adolescence[41(1)]:

> Just as adolescents commonly need to deny and repress new sexual and aggressive impulses, doctors will also do the same with their own conflicts, evoked by those of their patients. In time, healthy adolescents will be able to enjoy their new possibilities; unfortunately, clinicians, more often than not, are unable to.

In discussions with and among the medical residents, in addition to the taboo of suicide (category 1) and the peculiarities of pediatric care (category 2), five points were identified that justified the training gaps, three of which were directly related to suicidal behavior – 1) low exposure to the topic; 2) student disinterest; and 3) discomfort caused by the subject – and two considered relevant from the point of view of training – 4) organization of medical residency programs; and 5) anatomopathological impetus.

The low exposure to the topic was evident in the questionnaire responses and group interview statements. Interestingly, compounding the previous point, there was a lack of student interest in the subject, which allowed for criticism of the MR's active participation in their training. The following sentence illustrates this argument:

> *What I meant about not liking it, not that I wouldn't study it, but that I would avoid it as much as possible. It's very subjective and, in my view, it makes me a little lazy.* (R2, FG4).

The discomfort the subject provoked in the MRs highlighted how the concept of 'suicidality' is a difficult topic both professionally and existentially. This discomfort was used as a reason for disinterest and understood as a response to the taboos discussed here: "*We try to remain somewhat blind to this topic because we don't know how to deal with it very well*" (R1, FG3).

Expanding the curriculum and duration of residency programs in pediatrics could reduce the impact of point four, where residents indicated a lack of mandatory rotations in which they could receive adequate supervision. According to the participants, although expressions of suicidal behavior are frequent in society, these conditions do not appear in the daily lives of PRMs. The organization of residency programs does not always prioritize the conditions with the highest prevalence and morbidity/mortality. One R2 (FG1) suggested: "*A scenario should be included where we can experience these things in pediatrics*". It was also noted that residency program participants lack reflective spaces, under guidance, that provide emotional support in the face of the intense experiences of teaching and service: "*It would be interesting to have a place to discuss what we didn't know how to deal with, we didn't... we didn't deal with it, we lived it*" (R2, FG5).

Although a somewhat unoriginal point when discussing medical education, the imperative of the biomedical and anatomopathological model in the practice of MRs was highlighted. In the hegemonic conception of health and disease[42], the absence of a lesion in

a target organ or an objective examination that standardizes a diagnosis makes it difficult to understand psychic suffering, disqualifying it as impalpable: "*Mental health is not something palpable, in the sense that I can't auscultate it, see the temperature, there's no way to see what's wrong there*" (R1, FG1).

The research acknowledged that, in the face of taboos, inabilities, and discomfort, there are possible paths to change these formative trajectories so that they have a better impact on the lives of children and adolescents. One statement highlighted that raising awareness and addressing difficult topics such as suicidal behavior goes beyond the logic established in medical education, indicating that it is necessary to learn and teach in a 'different way':

> *We know how to do the physical exam, we know how to ask the questions, and then when it's all over, we don't know the diagnosis. But with suicide, we know the diagnosis, we understand that the child is at risk of suicide, but we don't have much of a way to deal with it.* (R2, FG5).

Strategic perspectives

Conducted before the implementation of the mandatory third year in PRM, this investigation also sought to indicate possible training strategies. Feedback was provided to residency programs, in an ethical return of research to the field[23]. However, no further evaluation was carried out on how the topic of suicidal behavior has been addressed in PRMs, which may constitute the subject of future studies.

Throughout the focus groups, many participants referred to the term 'discussion', in a qualitative and quantitative demand that activities, under the guidance of the PRMs, could address this topic from a care perspective and as a form of student psychosocial support. The recognition by the MRs themselves of their limitations and sensitivities was seen as positive.

Child and adolescent psychiatric interconsultation, whether in person or through a matrix support system, was identified by researchers as a relevant strategy, constituting a clinical link between pediatrics and mental health, bringing specialists to pediatric units, and not shifting the training of medical residents to external settings[14]. The training of pediatricians on this topic needs to be recognized as strategic for the care of children and adolescents, minimizing difficulties in accessing specific treatments. Training that develops internally within the PRMs tends to produce greater involvement and accountability among MRs, amplifying learned concepts.

The cross-cutting nature of mental health in pediatric training was another recognized strategy, seeking an articulation between biological, psychosocial, and cultural domains in the study of development[14]. In this regard, it is argued that not only psychiatrists are authorized for this supervision, but also other mental health and social work professionals. Different theoretical and practical approaches to emotional suffering are valid for pediatric training, especially if they are cross-cutting, longitudinal approaches articulated with the structure of the PRMs.

Final considerations

The methodological approach adopted here proved relevant to the proposed objectives, also allowing for academic feedback and support for the medical residents, and proposals for the Medical Residency Programs. It should be noted, however, that the in-depth look at five PRMs in pediatrics in the Metropolitan Region of Rio de Janeiro does not allow for a comprehensive understanding of the national pediatric reality. Even so, it is possible to recognize its relevance for organizational and curricular planning regarding pediatric training, especially those linked to SUS. As a limitation, it is acknowledged that the reality presented here was researched in 2018. It is understood, however, that the analyses carried out may still reflect the scenario of the PRMs,

considering the difficulties in implementing the curricular changes proposed in 2019.

It should be noted that, in 2018, the topic of suicidal behavior in childhood and adolescence gained greater penetration and impact in society, influenced by digital media. This discussion suggests that the reach of social networks in 2025 will be greater than that experienced during data collection, leading to a decision not to emphasize this topic, which can also be seen as a limitation. Therefore, the need to delve deeper into this theme from the perspective of social networks is acknowledged.

Suicide and suicidal behavior have been presented interchangeably throughout this text, both as expressions of self-inflicted violence and emotional suffering. They have not been argued here as synonyms, but as overlapping concepts, in which the term suicide, due to its semantic force, stood out in the participants' voices.

It is reiterated that gaps in training regarding suicidal behavior were prominent in PRMs, facilitating the influence of common sense, silence, and personal experiences in guiding pediatric care. The taboo surrounding suicide in children and adolescents reinforces previous taboos, such that pedagogical approaches need to address these taboos beforehand. Thus, revisiting the results of this study reaffirmed that, for the validation of suicidal behavior in childhood and adolescence as a health problem and one of the hallmarks of the pediatric epidemiological transition, changes in the training of professionals who care for children and adolescents are necessary. This becomes even more relevant when considering that many PRMs in the country are linked to public health units.

In conclusion, it is suggested that the findings on pediatric medical training may encourage its extrapolation to the training of other healthcare professionals. Furthermore, differences and limitations in this comparison are acknowledged, but the interdisciplinary dimensions of pediatric care are also considered. Medical training spaces need to be better shared with different professionals, highlighting the interdisciplinary and multiprofessional nature that this topic demands, especially given the complexities experienced in different stages of adolescence. Thus, by creating opportunities in the face of clinical and epidemiological challenges, suicidal behavior can become a motivator for the reorganization of teaching and service spaces in healthcare, as proposed by residency programs.

Authorship contributions

Silva Filho OC (0000-0002-5268-6097)* and Minayo MCS (0000-0001-6187-9301)* collaborated on the conception of the work, data collection, analysis and interpretation, writing and critical revision of the manuscript. Moura LNF (0000-0003-1148-324X)*, Puig DNS (0000-0003-0285-0714)* and Scardua MT (0000-0001-8642-6229)* collaborated on data collection, analysis and interpretation. All authors approved the final version of the manuscript. ■

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