

## Suicide attempts among children and adolescents: partial or total injury?

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**Abstract** *This study sought to verify the records on file and the number of cases of attempted suicide among children and adolescents who were attended by Emergency Care health professionals in the municipality of Matozinhos, Minas Gerais, Brazil. Documentary and descriptive research was conducted, the data for which was collected by means of an investigation of Outpatient Records from 2008 to 2010. Of the 73,000 files evaluated, those dealing with cases of attempted suicide among children and adolescents between the age of 3 and 18 years were selected. It was revealed that the health professionals, particularly physicians and nurses, fail to register the cases appropriately, invalidating information about the problem and potential prevention measures. The conclusion reached was that underreporting and the discrepancy of the diagnoses which were not duly referred to the competent agencies require rethinking and reviewing medical practices, and taking a systematic and careful look to address the individual as a complex whole.*

**Key words** *Suicide, Attempted suicide, Children and adolescents, Health professionals*

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## Introduction

Violence is a complex and multicausal phenomenon which has affected humanity for centuries. Current discussions regarding this issue suggest that it is a form of “renouncement” of the social and interpersonal relationships created by society. This assertion does not wish to detract from the importance of conflict in relationships as a driver of change and resignification, but rather broaden the perspective of conflict and understand this phenomenon’s peculiarities.

According to Minayo<sup>1</sup>, violence emerges to “[...] glorify causes, bring them to the public’s eye and, awkwardly, propose and demand change”. It is apparent that the field of health is one of the “privileged” settings, in which all of these demands are latently present. Health professionals receive victims of violence that perturb and destabilise a practice, enabling (or not) a change in perspective and action. Deslandes<sup>2</sup> sees violence as a great challenge for the health sector, since it is not an illness, but rather only the “effects” or consequences of an act and because it demands a change of praxis based on internal coordination and integration with other sectors. Moreover, it requires health professionals to notice the subject rather than merely the injury.

There are various forms of violence and it can manifest itself in many ways. The Brazilian health system adopts the International Classification of Diseases and Related Health Problems (ICD)<sup>3</sup>. The current classification does not directly specify the issue of violence, since it is not considered a disease from the biomedical point of view; instead, it condenses the phenomenon into “external causes” (V01-Y98) divided into unintentional, intentional and event of undetermined intent. Unintentional external cause encompasses traffic accidents, accidental poisoning, falls, exposure to fire, cold, drowning, exposure to heat, snakes, lizards, spiders, scorpions, bees, wasps, and complications of medical and surgical care. Intentional external cause includes suicide, homicide, war, and legal intervention<sup>4</sup>.

This study addresses the suicide and attempted suicide aspects of intentional external cause. Suicide is certainly not a recent phenomenon in our society. Durkheim<sup>5</sup> suggest that suicide dates back to early peoples and occupies a distinct position in society as an “heroic”, “honourable”, and later, “painful” (a sanction resulting from the “right”) act. Nowadays, one could say that this “right” has become a public health problem.

*[...] suicide is a universal phenomenon, dating back to ancient times, remembered through primitive mythology, criticised by religion as an act of rebellion against the creator, and appearing in many philosophical writings as a supreme act of liberty<sup>6</sup>.*

Marked by the creation of a special day to “alert” the public as to the gravity of the situation look – *World Suicide Prevention Day* on 10th September – suicide is still therefore very much a current issue of extreme relevance that mobilises the public sector to create policies and requires detailed analysis.

The World Health Organization<sup>7</sup> affirms that suicide is an act of aggression, and conceptualises it as an act of violence committed against oneself, with the clear intention to die. It also states that it is one of the top twenty causes of death among all age groups and a person commits suicide every 40 seconds. This is an alarming statistic, especially when you realise that the suicide rate among youth has increased to such an extent that this is now the group at highest risk.

It is important to note that, as a form of violence, suicide is also multifaceted, and the concept of suicide, its description and causes are complex. The choice of this definition is justified because it captures the main aspects of the object and setting of this study: emergency care.

The Ministry of Health confirms that “[...] Brazil is amongst the ten countries with the highest numbers of suicide”<sup>8</sup>. Within this context, the government produced “Suicide Prevention Manuals” for mental health and basic care professionals that detail the sociodemographic aspects of suicide and list history of attempted suicide and mental disorders as the main risk factors for suicide.

In the state sphere, it has been shown that suicide also occurs in adolescents under the age of 15 years. In 2004, the suicide rate among children and adolescents between 10 and 14 years of age in the State of Minas Gerais was the highest in the Southwest Region of Brazil<sup>8</sup>. However, these rates show only part of the picture, since the figures do not include attempted suicides.

Between January 2008 and August 2012, 6,883 hospitalisations were registered in the State of Minas Gerais due to intentional self-injury (attempted suicide), of which 1,052 were children and adolescents between zero and 19 years of age: equivalent to 15.3% of all cases<sup>9</sup>. At first sight, this figure is apparently insignificant. However, this figure does not show the whole picture, since it does not take into account attempted sui-

cides which are commonly not documented. This statement is echoed by the Ministry of Health: “[...] although records of attempted suicide are scarcer and less reliable, it is estimated that the rate is ten-times greater than the number of suicides”<sup>10</sup>.

*[...] in many settings, injuries do not have to be reported and information regarding injuries are not collected at any level. Other factors can also influence records, such as age, method used for attempted suicide, culture and health service access. In summary, in the majority of countries, attempted suicide rates are not clearly known*<sup>7</sup>.

This under-counting is cause for reflection regarding the type of care given by a healthcare provider: is care ethical, aesthetic and human? Considering that health professionals deal with the life and death dyad every day, the absence of data on attempted suicide is difficult to understand and disconcerting. While dealing with death as the finitude of life and a natural process is difficult, suicide is almost unacceptable, and a “healthy” subject that decides to take his or her life causes a swirl of confusion in people’s minds. This difficulty in understanding arises among health professionals that, on a daily basis, deal with people of a tender age who apparently only see a dark future ahead without any hope. After all, death is not associated only with a physical body, but with the subject who imprints meaning onto the objects and acts that he or she commits. Within this context, violence is understood not only as an injury, but also as a social act committed by a subject who will be received by another subject that also carries his or her own particular understanding and meaning of life and death.

With the purpose of “not wasting any more lives”, this study was undertaken based on a search of attempted suicide cases among children and adolescents between three and 18 years of age in the municipality of Matozinhos in the State of Minas Gerais treated in emergency care units (ECU) between 2008 and 2010.

Matozinhos is located 47 km from the state capital Belo Horizonte and has a population of 33,955 inhabitants. The population is predominantly young, and cases of attempted suicides are growing at an alarming rate. The town possesses the following healthcare facilities: a hospital, with an emergency care unit that began operating in the middle of 2013; 10 health centres, a Centre for Psychosocial Attendance (CAPS I); an adult outpatient clinic; mental health clinic for children and youth; and various private clinics and doctor’s surgeries.

The data used forms part of a Masters’ degree study titled: “Prevention of suicide and mental health promotion among children and adolescents in the municipality of Matozinhos”. The first phase of this study comprises a survey of the number of attempted suicides over the last five years using information obtained from specific health services. This work presents the data obtained from ECUs.

A careful analysis of survey data on the recording and number of attempted suicides among children and adolescents unveiled an interesting issue that deserves further analysis: similar demands were recorded differently by emergency care physicians and nurses. This finding calls for a more guided approach to registering of child and youth attempted suicide cases and the definition of the role of health professionals dealing with such cases, with emphasis on the outcome of emergency treatment (referrals) and communication between health services.

## Methodology

This study consists of a document search to determine the registration and number attempted suicide cases among children and adolescents treated by emergency care health professionals in the municipality of Matozinhos. Data was collected from a total of approximately 73,000 emergency care unit patient forms which were analysed to identify attempted suicide cases among children and adolescents between the age of three and 18 years.

Individuals that receive treatment at an ECU first fill out an admission form (pre-consultation) used by nurses to triage cases according to the Manchester Protocol which is passed on to the doctor on duty. It is important to note that urgent cases with immediate risk of death are treated first before carrying out these bureaucratic procedures.

All individuals that enter an ECU are registered even if they forgo treatment and therefore there are a number forms which include only the patient’s personal details. Furthermore, a number of patients go through the triage process but leave before being treated. Both situations were observed in this study, although in small numbers.

This study is limited by the fact that the forms present an often a crude register of cases characterised by limited information and detail and the absence of important data. This is a general

and persistent problem also affirmed by Minayo et al.<sup>11</sup>: “[...] information from hospital statistics is generally a target of criticism due to the limitations posed by the quality of the data they provide”. However, despite the precarious nature of the data, it is the best source of information available for this study.

Using the data collected from the ECUs, the number of attempted suicide cases were counted and analysed based on the corresponding categories for the various situations encountered: a) cases defined using a corresponding ICD category for attempted suicide (X60-X84); b) cases without a corresponding ICD category, but with a written description (attempted suicide, or attempt at self-extinction, or attempt to take own life); c) cases defined using a different ICD category, but with a written description (attempted suicide, or attempt at self-extinction, or attempt to take own life); d) suspected cases defined using a different ICD category; e) suspected cases without a corresponding ICD category.

Attempted suicide corresponds to the ICD categories X60toX84 (intentional self-inflicted injuries). Suspected cases are those where there is not enough data to verify intentionality and also those in which only the consequences of a given act are registered. An example eis the description referring to an adolescent with cut wrists whose wounds were sutured but for which no diagnosis hypothesis was generated. Was this accidental or intentional?

In an attempt to quantify cases of attempted suicide, all such occurrences among children and adolescents were registered together with cases referred to some form of “mental health” service (Psychologist, Psychiatrist, Centre for Psychosocial Attendance, mental health clinic). Furthermore, an attempt was made to ascertain whether health professionals communicated with other services. For the purpose of this study child was defined as aged three to 12 years, while adolescent was 12 to 18years<sup>12</sup>.

Descriptive statistical analysis was undertaken using the SPSS software to highlight the most relevant aspects of the data. The authors opted to present examples of cases and discuss the role of emergency healthcare professionals in the treatment of attempted suicide cases.

This study was approved by the Research Ethics Committee at the UNA University Centre.

## Results

A total of 136 cases of suspected attempted suicide were observed. Thirteen of these cases were described as attempted suicide, 11 were registered without a corresponding ICD category, and two were recorded using a different ICD category which did not correspond to the declared diagnosis hypothesis. The remaining cases were considered attempted suicide, lacking sufficient clear information to confirm “intentionality”.

An analysis of Graph 1 shows that none of the cases were specifically described as attempted suicide using a corresponding ICD category. The analysis of the patients’ notes described above showed that there were in fact 42 cases in 2008 (15 children and 27 adolescents), 54 cases in 2009 (19 children and 35 adolescents), and 40 cases in 2010(nine children and 31 adolescents). Consequently, only 9.6% of the total number of cases (136) were diagnosed as attempted suicide.

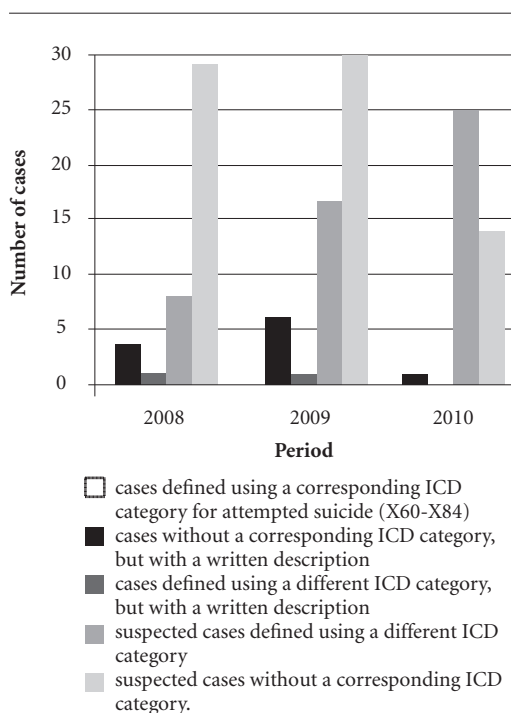
Under the SUS clear, legible and accurate annotation of information regarding the health of a patient is advocated as a right of the service user. When health professionals do not adequately fulfil their function, they not only infringe this primary right, but also hinder access to a comprehensive universal health service<sup>13</sup>.

Poor documentation prevents the effective fulfilment of one of the core objectives of the SUS: the creation of effective health policies. Not registering the problem is tantamount to denying that it exists, and results in inadequate attention to the issue and investment in the design and implementation of effective healthcare policies to address this problem.

Humanizing care of children and adolescents who attempt suicide means that it is necessary to value all aspects of these subjects, including sociopsychological dimensions, and requires co-responsibility in care and embraces the inseparability of the subject and health services.

### Cases defined using a corresponding ICD category for attempted suicide

Attempted suicide corresponds to the ICD categories X60 to X84 (intentional self inflicted injuries). None of the cases were specifically described using this classification. This finding poses the following questions regarding health



**Graph 1.** Registered cases of attempted suicide among children and adolescents in Matozinhos during the period 2008 – 2010.

professionals: what are the causes of poor documentation? Does the risk of death among children and adolescents cause unbearable subjective discomfort, blocking their ability to get involved? Or does the daily routine allow them to become impregnated with impersonality, tradition and *lack of authenticity*?

**Cases without a corresponding ICD category, but with a written description (attempted suicide or attempt at self-extinction or attempt to take own life)**

The largest number of declared cases of attempted suicide were registered in this category. Of the 11 cases found, four occurred in 2008, six in 2009, and just one 2010. The health professionals described the occurrence but did not classify it as a self inflicted injury. This is an indication of an irresponsible professional attitude to the patient and society as a whole, since it prevents further actions and procedures that would

guarantee comprehensive care. After all, the true meaning of comprehensiveness is defined by healthcare needs, such as those highlighted by early diagnosis or risk factor reduction.

**Cases defined using a different ICD category, but with a written description (attempted suicide or attempt at self-extinction or attempt to take own life)**

Two cases were defined using different ICD categories: T65.9 (toxic effect of unspecified substance) and F10.2 (mental and behavioural disorders due to use of alcohol-withdrawal symptoms).

It is important to note that according to the ICD recommendations, causes of death and/or attempted suicide should be tabulated preferably using the codes outlined in chapter XIX (Injury, Poisoning and Certain Other Consequences of External Causes S00 –T98) and chapter XX (External Causes of Morbidity and Mortality V01 – Y98)<sup>3</sup>.

The data confirms that the majority of doctors do not choose to use chapter XX for diagnosis hypothesis and are “tied and limited” to the consequences of committed acts, i.e., the injury, fracture or intoxication. This means that the child or adolescent who sees taking his or her own life as the only way out from his or her suffering does not receive adequate care. The medical procedure for a case with cut wrists, for example, is limited to “suture” and the diagnosis hypothesis is “injury to an *unspecified* part of body” (*authors’ emphasis*).

**Suspected cases registered using a different ICD category**

The following paragraphs summarise two cases of suspected attempted suicide registered using a different ICD category in an attempt to clarify the discussion.

Case 1 – adolescent aged 18 years received in July 2009. Description of complaint: “exogenous intoxication through swallowing rat poison three hours ago”. ICD: T65.9 (“toxic effect of unspecified substance”).

This case reveals that the information given is incongruent: if intoxication was caused by swallowing rat poison, why does the form state



“unspecified substance”? This case is not an exception, since a number of forms contained this type of contradiction.

Case 2 – child aged four years received in June 2010. Description of complaint: “started having fever and vomiting this afternoon. Took 10 pills of dipirona around 40 minutes ago”. ICD: J 22 (unspecified acute lower respiratory infection).

Again there appears to be apparent negligence or lack of attention with respect to how the case is registered, shown by a lack of convergence between the demands expressed by the nurse and the clinical examination made by the doctor. Should we maintain silence regarding such situations and therefore go against the ideal of a system that assures universal equal access to comprehensive health care as idealised by the constitution?

Various studies show a significant gap between ideal and reality, where the dream of an idealised health care system does not materialise. The “production” of care is not embodied in real-world health settings<sup>14</sup>.

These suspected cases were registered using the following ICD categories: F10.2 (mental and behavioural disorders due to use of alcohol - dependence syndrome), T18.9 (unspecified foreign body in digestive system), T65.9 (toxic effect of unspecified substance), R10.1 (pain localized to upper abdomen), F10.0 (mental and behavioural disorders due to use of alcohol), R07.0 (sore throat), T14.1 (injury to unspecified part of body), T30.0 (burn of unspecified body region, unspecified degree), J03.9 (acute tonsillitis, unspecified), J.22 (unspecified acute lower respiratory infection), R60.9 (edema, unspecified) and K12.1 (other forms of stomatitis).

Two of these categories (T65.9, F10.2) were also found in cases where a different ICD was used and where the written description was “attempted suicide”. This finding raises questions regarding the real number of cases of attempted suicide that received emergency treatment and what the emergency healthcare professionals in Matozinhos consider to be attempted suicide.

#### **Suspected cases without a corresponding ICD category**

Two examples of suggested cases of attempted suicide where there was not enough data to verify intentionality may be cited.

Case 1 – child aged five years received in August 2008. Description of complaint: “knife cut on the left hand”. ICD not informed.

It is not clear whether this was attempted suicide because the injury could have been accidental. However, given the omissions in other cases, this conclusion should not be accepted immediately without first investigating all cases and hearing the subject’s own version of events.

Case 2 – Adolescent aged 16 years received in November 2009. Description of complaint: “Deep cuts and bruises on the left hand (glass) radial artery lesion + flexor tendon of the left ring finger”. ICD not informed.

How was this adolescent’s anamnesis created? What kinds of questions were asked about the patient’s life story? A deep cut on the wrist calls for a more detailed investigation of the patient’s needs. Not being open to listening to the biological, psychological and social being, makes it impossible and irresponsible to carry out a diagnosis. Given the serious nature of the injury, one must question whether the omission of this problem by the health professionals could be interpreted as negligence. It is also important to highlight that there is no record of the account of this adolescent and his/her companion: how did this adolescent injure himself/herself? Silencing the suffering supposedly caused by the cuts on the adolescent’s wrists is simply unacceptable.

The question does not boil down to just “changing or including” an ICD category, but rather to the need for a paradigm shift. It is evident that the emergency care health professionals in Matozinhos omit information, possibly in search of consolation to handle the real horrors of children and adolescents wanting to die. In this respect, Combinato and Queiroz<sup>15</sup> claim that although natural “[...] for modern western man, death has become a synonym for failure, impotence and shame. Humans try to defeat it at whatever cost, and when they are not successful it is hidden and denied”. As every choice and action has a consequence, poor documentation of occurrences makes it “inexistent” and it therefore becomes “unnecessary” to attempt to deal with it or prevent.

It could also be said that responsibility for care stems from the knowledge and experience of different social actors, each of which have their own life story and world view that drives care in the health world, whether in the daily routine of a mental health outpatient clinic in small provincial town, which has its own set of micro-politics, or in a large hospital in a major urban area.

Graph 2 shows the small number of referrals and attempts at communication with other services, demonstrating the “lack of involvement” of

health professionals in the care and treatment of the subject.

Only five of the 136 cases were referred to the mental health clinic for children and youth or to a similar service. It is interesting to note that the number of general referrals dropped after the clinic opened: only one in 2009 and one in 2010. This is cause for reflection regarding the development of the municipality's healthcare network and its implications for referrals: how do the different services communicate? Is there intersectoral collaboration? Does it actually work as a network? Is each service aware of the work developed by the other services that make up the municipality's public health system? Do professionals view the system in a holistic manner?

Matozinhos does not have a municipal child and adolescent mental health policy and the children and adolescent support network is disorganised. Therefore, the health, care, sport, security, and education services, and municipal councils do not develop actions focused on citizens, but rather concentrate on their goals and productivity, thus thwarting the possibility of an integrated approach to prevent cases of violence and promote health and quality of life. Emergency healthcare professionals mask an issue which is a social governance problem. These individuals are invisible, not only to the health service, but to the community as a whole. How is it that a child and adolescent support network does not look at and listen to its target public? Given that the

common thread between all services and policies is precisely the subject, communication between the sectors must pay proper regard to his or her needs and it is therefore fundamental that those involved realize that children and adolescents are citizens who are coresponsible for their own life and death.

These questions suggest a fragmented vision of the subject as a dichotomised, dismantled being which is, Cartesianly speaking, divided into parts. Within this reductionist approach, care is also reduced to complaint, medicalisation and discharge without any implications and coreponsibility for life.

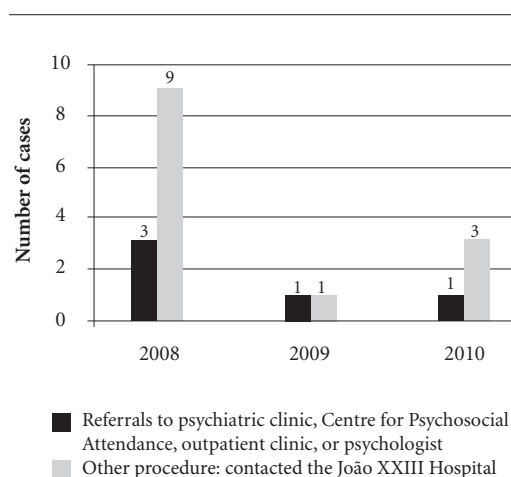
## Discussion

Talking about and treating attempted suicide among children and adolescents is difficult and the issue often ends up not being addressed. The World Health Organisation (WHO) cites the belief that children take their own lives as one of the great world myths.

Myth 10: *Children do not commit suicide, since they do not understand the finality of death and are cognitively incapable of engaging in a suicidal act.* FALSE *children commit suicide and whatever gesture at whatever age should be taken very seriously*<sup>16</sup>.

Although death is a natural, Western man is affected by death due to its negative connotations. Combinato and Queiroz<sup>15</sup> reinforce the symbolic dimension present in this event, reminding us that dying is "[...] a phenomenon impregnated with values and meanings that depend on the sociocultural and historic context in which it manifests itself". Therefore, we should not forget that health professionals are, above all, biopsychosocial subjects. The profession bears the burden of "saving lives": of those who had the misfortune of "suffering" the threat of death. However, subjectivity and the symbolic dimension present in this act do prevent these subjects, and also health professionals, from realising the sense of urgency in a healthy person that chooses to die<sup>17</sup>.

A study involving health professionals that deal with self-inflicted injury cases in a public hospital in São Paulo highlighted that, in addition to poor documentation, the public stigma of suicide also affects (weakens) care<sup>18</sup>. The author highlights the need to recover the true notion of suffering. Other important aspects raised by the author include: paradigm shift (holistic vision of the subject that suffers), humanisation of the



**Graph 2.** Referrals and other procedures undertaken with cases received in emergency health services in Matozinhos during the period 2008 – 2010.

health service, and, more importantly, legitimacy and listening to the subject that suffers.

Conte et al.<sup>19</sup> give an account of the experiences of a suicide prevention programme in the South Region of Brazil (Candelária in the State of Rio Grande do Sul) where they investigated lack of listening among health professionals. The solution found was to demystify death due to suicide and thus create new opportunities to talk about the issue, develop professionals' capacity to identify risks, their awareness of suicidal ideation, and empathy with families that had lost members before the program started. Based on these initial activities, it was possible to develop the Individual Therapy Plan, based on the unique nature of each case, working with the family, patient access to services and medication, possible treatment in primary healthcare units, social network listening, coresponsibility and teamwork, systematic close monitoring of risk situations and the importance of discretion and ethics.

Social suffering in modern times is the result of violence committed by the social structure and the injurious effects of power that characterise social organisation<sup>20</sup>. Its multiple dimensions limit the human condition and pose a number of challenges for society. Suicide or attempted suicide is thus greater than the group or individual, since it is fruit of the social experience which is often trivialised and withdrawn, principally by the professionals who deal with the life and death of subjects.

The question is: do these "specialist" health professionals care for the person or part of the person? The biomedical paradigm that forms the basis of the training of these professionals hinders their capacity to perceive the uniqueness of the subject and the fact that it is not "part of the person" that dies, but rather the whole person, the subject, that lives or dies, and not the arm with cut wrists. After all, a person can live without an arm, but the arm does not exist without the subject. Recalling the words of Merleau-Ponty<sup>21</sup>: "I do not have a body, I am my body".

What differentiates an injury or intoxication from an attempted suicide is intentionality. It is therefore almost impossible to confirm that the cuts on the patient's wrists were an intentionally self-inflicted injury, since the only person that can attest to his or her "intentions" is the actual subject, and not the injury (consequence of an act and of a choice). Therefore, to shed light on a diagnosis hypothesis, it is necessary to look at the whole picture and, moreover, listen. Certainly, due allowance must be made for the peculiar-

ities of professional training and health service. Effective listening does not mean becoming a psychologist, but looking beyond the injury and attempting to understand the whole picture.

Maybe it is one of the ways that health professionals have found to deal with the upset and discomfort caused by death. A recent study<sup>22</sup> concluded that doctors suppress the experience of psychic suffering when leading with death, thus hindering the process of reflection and adequate care. Afonso<sup>23</sup> goes much further in a review of the book "On Death and Dying", when he says that the text affirms that our society avoids and ignores death and that doctors and other health professionals that work in this context do not know how to deal with a situation where a subject needs and requests care. He goes on to suggest that doctors should reflect on their own death, develop empathy for patients and put themselves in the shoes of those who are suffering and asking for help and need to be treated and listened to during their ordeal. By denying the whole picture and caring for only a specific part of the problem, treatment is limited to caring for the consequence of a given act committed or suffered by an individual.

Looking at the whole picture means considering the possibility that the person is not just a "victim or patient", but the subject of his or her own story and treating the whole patient. The Brazilian health service's National Humanisation Policy calls this "[...] a change in care culture and the management of work processes [...]" and, with respect to the emergency treatment of patients, goes on to highlight that health professionals must respect the needs and differences of the subject<sup>13</sup>.

## Final considerations

While it would be utopian and hypocritical in postmodern times to suggest that one kind of knowledge alone is capable of solving everything, it is also naive to believe that the whole is the sum of its parts. To perceive the adolescent beyond the cut wrists, health service professionals must embody the ideals of "humanisation" and "comprehensiveness", where comprehensiveness is understood as a mixed notion loaded with feeling. It is therefore fundamentally important to shun the fragmented approach to health and promote an intense debate to lay a path where health professionals and all those involved in the child and adolescent support network look beyond super-



ficial demands and take on responsibility, not just for undertaking a correct diagnosis of attempted suicide, but also for taking the necessary initiatives to treat the situation.

Realising that a subject's care needs go beyond suture and helping the patient to believe that there is an alternative and to choose to live is not only vital, it is human, even given the peculiarities of a health system that (theoretically) treats emergency cases. But what makes health professionals omit information in such cases? How is it possible to diagnose attempted suicide among children and adolescents in a relatively small town? Is it better to evade responsibility? It is important to highlight that the existence of a child and adolescent support network that develops integrated actions with other sectors means that the "problem", and therefore each case, life and subject, is the responsibility of *all those in-*

*involved*. Sharing the responsibilities and difficulties of complex situations strengthens the sectors and professionals involved. The effective participation of health managers and the community is also important since it is a citizen's right and health service's duty to contribute to the well-being of the whole community.

The data obtained by this study showed a number of gross defects in diagnosis and, principally, in referrals demanded both by the subject seeking emergency care and the patients' family members. Therefore, Flexnerian approach is not solely to blame and changes to the curriculum are not the only solution. However, changes in attitude are needed.

These are uncomfortable assertions which call for further investigation. It is believed that by forcing a paradigm shift among public health professionals and simply listening to the subjects it is possible to create innovative solutions.

## Collaborations

MAG Alves and MMM Cadete participated equally in all stages of this study and the writing this article.

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