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Projection of the preventive-suicidological competence of the Comprehensive General Medicine specialist in the care context

Projection of the preventive-suicidal competence of the Comprehensive General Medicine specialist in the care context

Project of preventive-suicidological competence of specialist in Comprehensive General Medicine in the context of care

Rita Irma González Saturday I* https://orcid.org/0000-0002-6336-1271

Roberto Hernández Álvarez II https://orcid.org/0009-0000-4008-3611

Rafael Claudio Izaguirre Remón II https://orcid.org/0000-0001-6295-3374

Osbel Martínez González III https://orcid.org/0000-0002-8214-1039

Yadira Lahera Ramírez I https://orcid.org/0009-0003-6980-7312

[Yo]Granma University of Medical Sciences. Manzanillo Faculty of Medical Sciences. Granma, Cuba.

[II]Celia Sánchez Manduley Provincial Clinical and Surgical Hospital in Manzanillo, Granma, Cuba.

[III]University of Granma, Cuba.

Corresponding author: E-mail:riar@infomed.sld.cu

SUMMARY

The limited control of suicide attempts by Comprehensive General Medicine specialists at the primary care level reflects limitations in the assessment and intervention of patients at risk for suicide. This research aims to project the structural and functional elements necessary for the

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development of preventive-suicidological competency in this professional.HEconducted a descriptive observational study in a study population comprised of 27 specialists and 10 professors who were members of basic work groups. The dimensions and indicators used allowed for the processing of information derived from the use of empirical methods (survey, observation, and analysis of the activity's products) and statistical-mathematical methods. Limited knowledge was obtained related to suicidology and the application of the clinical epidemiological method (77.7%), and they have insufficient inquiry, explanation, and argumentation skills during care for at-risk patients (92.5%) conducive to basic performance. It is concluded thatThe elements of the preventive-suicidological competence of this specialist are projected as a pedagogical construct.to channel successful performance.

Keywords: Clinical Competence; Performance Analysis; Suicide Attempt.

SUMMARY

The lack of control of the suicide attempt by the specialist in Comprehensive General Medicine (MGI) at the primary level of care expresses limitation of the study and intervention in the patient at risk of suicide. This investigation aims to project the structural and functional elements necessary for the development of preventive-suicidological competence in the MGI specialist. A descriptive observational study was carried out in a study population made up of 27 specialists and 10 professor's members of basic work groups. The dimensions and indicators used allowed to process the information from the use of empirical methods (survey, observation and analysis of the products of the activity) and statistical-mathematical methods. Limited knowledge enabled to suicidology and application of the epidemiological clinical method (77.7 %) is obtained, they have insufficient skills of inquiry, explanation, argumentation during the care of the risk patient (92.5 %) leading to a basic performance, which reveals the need to delimit this competence. It is concluded that it is possible to project the elements of the preventive-suicide competence of this specialist as a pedagogical construct to channel an effective treatment that conditions a successful performance, from the intention of its training process in other stages of the research.

Keywords: Clinical competence; Performance analysis; Suicide attempt.

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SUMMARY

The poor control of suicide attempts by a specialist in Comprehensive Geral Medicine does not reach the level of primary care expressed by limitations in the study and intervention of patients at risk of suicide. The objective of this research is to design the structural and functional elements necessary for the development of professional preventive-suicidological competence. A descriptive observational study was carried out in a population of study composed by 27 specialists and 10 professors who were members of basic work groups. The dimensions and indicators used make it possible to process information from the use of empirical methods (research, observation and analysis of activity products) and statistical-mathematical methods. We obtained limited knowledge related to suicidology and the application of the clinical epidemiological method (77.7%), due to insufficient research, explanation and argumentation skills during the care of patients at risk (92.5%), or leading to basic performance.

Keywords: Clinical competence; Performance analysis; Suicide attempt.

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Introduction

Some research has focused on the competent professional in Cuba and within the medical sciences, (1,2) all stand out from a dialectical materialist conception of the construct, with an integrative approach applied to the context.

In the Americas, Cuba is recognized for the results of its health system, particularly for its Primary Health Care (PHC) strategy. The management of the Comprehensive General Medicine (CGM) specialist is focused on the promotion and prevention of communicable and non-communicable diseases, as well as health risks, including suicide attempts (SI).

The excessive national and provincial increase in suicide attempts (SI) in Cuba represents a health problem with a rate of 9.9 per 100,000 inhabitants. Granma is the third most represented province in the country with a rate of 12.7. (2,3) A primary care physician is needed to reverse these health statistics; however, their performance is limited, influenced by some weaknesses in the preparation process, an analysis that can be seen in various studies conducted in the municipality of Manzanillo, in the eastern province of Cuba. (4-6)

From the factual diagnosis combined with the authors' teaching and care experience, the level of preparation of the MGI specialist is confirmed, which allows them to reveal certain manifestations: low willingness to carry out suicide prevention, with little practice of professional actions by some specialists, insufficient comprehensive attention to the mental health program, given the attention overload implied by the large number of health programs under their charge, low priority to methodological treatment from science and control of the preventive-suicidological process developed by the Basic Working Group (GBT) for this professional in their health area, which does not favor the resolution of this damage to health as a professional problem of the context, and insufficient improvement activities, focused on the content of suicide prevention.

The situation described shows that research related to this issue is still needed, which leads to the scientific problem: the inadequacies in the training of MGI specialists limit their performance in the study and intervention of patients at risk of suicide.

Consequently, the object of study is defined as: the process of professional training by competency in the Comprehensive General Medicine specialist, to contribute to the development of the specific preventive competence necessary for this professional, so that the present research has as its field of action: the development of preventive-suicidological competence in the MGI specialist in the PHC.

In this sense, scientific research reveals an epistemic gap in the argumentative shortcomings of the competency required by MGI specialists, from undergraduate and postgraduate training, to improve their professional performance in the prevention and control of this mental health problem.

The references presented allow us to understand the preventive-suicidological competence as a complex process that integrates cognitive, metacognitive, motivational components and personality qualities, which determine a superior performance in the prevention of SI as a problem to be solved in the context of PHC, from the integrated management of theoretical and methodological contents to deploy the preventive process, within an assertive climate of exchange, humanism, commitment, tolerance, support and an ethical and persevering attitude in the search for solutions.

Accordingly, the development of preventive-suicidological competence is defined as the conscious pedagogical process that allows to articulate the cognitive and the affective-motivational in the learning of theoretical and methodological contents, to design the attention to this health problem in the APS, which includes updating, expanding and perfecting the essential knowledge of this prevention, from the formative actions of the GBT, with a transformative character, in the analysis of the information through the use of methodological resources to execute the specific activities that allow it to act on this problem and generalize the results of its performance in correspondence with the expected achievements if it is intended at a higher stage of the investigation from the application of a pedagogical strategy, aspect that is not part of the results that are socialized here.

The theoretical systematization of the object of study makes it possible to determine the need to explore a little-explored path, based on the insufficient approach to a competency to prevent SI in the training process of the MGI specialist, which allows us to specify as an objective of the research the project of the structural and functional elements necessary for the development of the preventive-suicidological competency in this professional.

Methods

A retrospective descriptive observational study was carried out at the Dr. Francisca Rivero Arocha Teaching Polyclinics No. 1 and Dr. Ángel Ortiz Vázquez Teaching Polyclinics No. 2 during the 2021-2022 period. These studies included 27 MGI specialists located in urban medical offices in the city of Manzanillo. These specialists were intentionally chosen because

both institutions had the highest number of IS patients. Information was also obtained from 10 GBT member professors from both institutions. Informed consent was requested from all of them for the research. To evaluate the development of the competency, dimensions and indicators established by the authors were identified. These allowed the processing of information from the use of empirical methods (surveys, observations, and analysis of the activity's products). These were:

1. Knowledge necessary for suicide prevention of MGI.

1.1 Mastery of basic conceptual aspects of suicidology during the clinical interview and completion of normative documents (individual and socio-family risk factors, management of suicidal crisis and its principles).

1.2 Mastery of theoretical elements specific to primary care (dispensary groups, prevention levels, content of specific activities).

1.3 Mastery of the theoretical aspects of the Suicidal Behavior Prevention and Control Program.

2. Procedures for suicide prevention.

2.1 Management of methods, instruments and techniques to carry out suicide prevention.

2.2 Analysis of the information obtained.

2.3 Generalization of the results of suicide prevention.

3. Qualities and values for suicide prevention.

3.1 Provision for carrying out suicide prevention.

3.2 Responsibility, solidarity, humanism, support during the suicide prevention process.

3.3 Autonomy and cognitive independence.

3.4 Transformative attitude.

4. Methodological treatment from science and control of the suicide prevention process developed by the GBT at the MGI in its health area.

4.1 Conception of training from the undergraduate and graduate study plan.

4.2 Evaluation of the quality of the completion of the normative documents of the Individual Clinical History (ICH) and the Family Health History (FH).

4.3 Evaluation of the IS follow-up protocol established in the National Program for the Prevention and Control of Suicidal Behavior (the first consultation after IS should explore the personal and family history of suicidal behavior, lethality of the method used, severity of the circumstances, seriousness of the intention, possible motivational or causal factors, risk factors, and investigate alterations in family interrelationships).

4.4 Evaluation of the quality of IS patient surveys and the Notifiable Disease (EDO) card.

4.5 Evaluation of the quality of specific activities that allow monitoring IS as a health problem (dispensary, home admission and ASIS).

5. Methodology used by GBT teachers to stimulate understanding of the theoretical and practical aspects of suicide prevention in methodological and improvement activities.

5.1 Teaching methods used (passive/reproductive and active/problematic).

5.2 Strategies used to encourage professional involvement and understanding of the significance of caring for patients at risk of suicide (group discussion, teamwork, learning situations in real or simulated contexts, analysis of problematic situations within the framework of collaborative work).

5.3 The relationship between the professional responsible for the activity and the MGI specialist as a student is directive or dialogic.

5.4 The nature of communication between the teacher responsible for the methodological or improvement activity and the MGI is informative; bilateral, receptive or open, clear, and fluid.

General rating scale

Very Low (VL): When two or more indicators of each dimension are evaluated as Very Low.

Low (B): When two or more indicators of each dimension are evaluated as Low.

Medium (M): When two or more indicators of each dimension are evaluated as Medium.

High (A): When two or more indicators of each dimension are evaluated as High.

Very High (MA): When two or more indicators of each dimension are evaluated as Very High.

By triangulating the information obtained from the observations and the analysis of the products of the activity, the level of performance of the MGI specialists to execute suicide prevention was determined. Not only was their knowledge of suicide prevention evaluated but also how they do it in the care context. This allows for classification into a basic

performance level and a higher performance level, based on the criteria developed for the analysis: quality of knowledge related to suicidology and medicine when conducting consultations and interconsultations with at-risk patients (criterion 1), inquiry skills, explanation, and argumentation during care for at-risk patients and the selection of techniques and instruments for their assessment (criterion 2), use of metacognitive processes to analyze and record the information obtained in regulatory documents (criterion 3), and the level of development of qualities and values in their care management during consultations, interconsultations, and home visits (criterion 4).

In addition, descriptive statistics with percentage analysis were used to process the quantitative diagnostic data. The research is based on scientific and pedagogical ethics, considering informed consent, data confidentiality, respect for the dignity and integrity of participating subjects, and adherence to medical bioethics as principles of moral regulation of scientific practice.

Results

By triangulating the information obtained, a detailed analysis of the behavior of the established dimensions is carried out to determine the development of the preventive-suicidological competence that impacts the level of performance achieved (Table 1).

Table 1. Dimensions to evaluate the development of the preventive-suicidological competence of the MGI specialist based on the applied surveys.

Dimensions / Indicators		Scale									
		Very Low		Low		Half		High		Very High	
		No.	%	No.	%	No.	%	No.	%	No.	%
1. Knowledge necessary for the MGI suicide prevention process	1.1	8	29.6	7	29.9	8	29.6	4	14.81	-	0
	1.2	5	18.5	17	62.9	5	18.5	0	0	0	0
	1.3	3	11.1	17	62.9	7	29.9	0	0	0	0
2. Procedures for the suicide prevention process	2.1	19	70.3	4	14.8	4	14.8	0	0	0	0
	2.2	8	29.6	10	37.0	9	33.3	0	0	0	0
	23	17	62.9	10	37.0	0	0	0	0	0	0
3.Qualities and values for the suicide prevention process	3.1	8	29.6	11	40.7	8	29.6	2	7.4	0	0
	3.2	3	11.1	1	3.7	5	62.9	18	66.6	0	0
	3.3	17	62.9	7	29.9	3	11.1	0	0	0	0
	3.4	19	70.3	6	22.2	2	7.4	0	0	0	0

4. Methodological treatment and control of the preventive process of GBT to MGI	4.1	21	77.7	6	22.2	-	-	0	0	0	0
	4.2	15	55.5	10	37.0	2	7.4	0	0	0	0
	4.3	11	40.7	16	59.2	0	0	0	0	0	0
	4.4	20	74.0	7	29.9	0	0	0	0	0	0
	4.5	18	66.6	6	22.2	3	11.1	0	0	0	0
5. Methodology used by the GBT to stimulate understanding of the suicide prevention process	5.1	14	51.8	13	48.1	0	0	0	0	0	0
	5.2	19	70.3	8	29.6	0	0	0	0	0	0
	5.3	21	77.7	6	22.2	0	0	0	0	0	0
	5.4	22	81.4	5	18.5	0	0	0	0	0	0

Source: Surveys

Table 1 shows, in the dimension of knowledge required by the MGI specialist for suicide prevention, notable deficiencies in the indicator of mastery of basic conceptual aspects of suicidological science, classifying in the categories of very low 29.6% and low 29.9%. The mastery oftheoretical elements of primary care, where 62.9% reported low knowledge of individual, family and social risk factors.

Regarding the suicide prevention procedures dimension, in the indicator for managing suicide prevention methods, instruments, and techniques, 70.3% identified their knowledge as low or very low.

In the dimensionqualities and values of the specialist for suicide prevention in more than 70% there is evidence of low and very low willingness to carry out suicide prevention, despite the fact that they recognize and demonstrate in the care of this type of patient at high levels (66.6%) of values of solidarity, humanism and support. The low mastery of autonomy and cognitive independence (62.9%) is notorious, which limits their transformative attitude to change the risk or lethality condition of the patient attended.77.7% of GBT faculty members believe that, although there is a training intention in prevention from the integrative discipline MGI in the undergraduate program and the courses and/or modules in the residency, the training concept is not sufficiently intentional with respect to IS.

Table 2 shows the performance levels that the MGI specialist must possess.The basic performance level assesses 77.7% of specialists with limited knowledge, minimally complying with the procedures of the clinical-epidemiological method. 85.1% have insufficient inquiry skills when caring for at-risk patients and selecting the techniques and instruments used for each life stage. Meanwhile, 92.5% stand out with poor metacognitive processes to process

and record information obtained in the documents that govern their work (HCI, HSF, EDO card, ASIS). 40.7% of the professionals surveyed express a low level of qualities and values in their care management.

At the higher performance level, the criteria express very low values: only 22.2% have a thorough knowledge of suicidology and mastery of the clinical method. Only 14.8% have adequate patient inquiry and examination skills; only 7.4% are able to record information in regulatory documents; and 59.2% express qualities and values in their care management.

Table 2. Performance levels of MGI specialists in implementing suicide prevention according to established criteria.

Criteria	Performance level essential		Performance level superior	
	No.	%	No.	%
1. Quality of knowledge related to suicidology and medicine.	21	77.7	6	22.2
2. Inquiry skills during care of at-risk patients and selection of techniques for their evaluation.	23	85.1	4	14.8
3.Using metacognitive processes to record information in regulatory documents.	25	92.5	2	7.4
4. Level of development of qualities and values in their healthcare management.	11	40.7	16	59.2

Source: Surveys

The authors distinguish the determination of procedural axes in correspondence with the core content of suicide prevention, which allows the expected learning of the MGI to be grouped by a specific performance in the competence. They break down the knowledge inherent to the competence, as well as the metacognitive, motivational components and personality qualities that this professional must possess for the development of the preventive-suicidological competence. Consequently, the preventive-suicidological competence of the MGI specialist in PHC is defined as a pedagogical construct whose structural synthesis is reflected in Table 1, Table 2 and Table 3.

Table 1. Units of competence and elements to consider.

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Table 2. Problems to be solved and indicators to be evaluated in the competition.

Problems and uncertainties: 1. Contextual problems linked to the prevention of suicide attempts. couraging the transformative nature of the preventive-suicidological actions of the MGI specialist in APS. Use of available theoretical and methodological resources for suicide prevention. Practical articulation of preventive knowledge. Socio-professional environment of preventive-suicidological action.	Performance indicators: (Specific activities to be done in the competition) By procedural axis, from the theoretical, methodological and practical preparation to manage the preventive-suicidological process. By process axis, achievement of performance levels from their competence to know, know how to do, be and know how to coexist in the context of the suicide prevention process in PHC.

Table 3. Essential knowledge to master and evidence to verify.

Essential knowledge			Evidence
Dimension affective motivational	Dimension cognitive	Dimension of the do	
• Collaborative work in the context of PHC. • Creativity, flexibility and independence in the practice of suicide prevention.	• Conceptual mastery of manifestations of suicidal behavior. • Mastery of the clinical-epidemiological method applied to the prevention of suicidal behavior. • Mastery of mental health prevention in APS. • Mastery of guides, instruments and scales for preventive-suicidological activity.	• Evaluative analysis of mental health. • Design of the suicide prevention process in compliance with the regulatory and ethical framework.	Evidence of knowledge: • Design and understanding of the comprehensive preventive-suicidological process in primary care. Evidence of attitude: • Assessment of personal involvement in the suicide prevention process in primary care. Evidence of doing • Personal professional performance in suicide prevention. • Professional evaluation. Product evidence: • Favorable mental health indicators and transformation of suicidal behavior in the care area.

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Discussion

Current research reveals the low training priority that primary care professionals have received in suicide prevention, with an emphasis on the IGM specialist. Other studies have also socialized this by claiming the leading role of the family physician guided by the GBT to identify and transform suicidal potential, as a weakness of the primary system. (3,7) Several studies call for the need to empower the primary care physician in preventing this damage to health. (8-10)

Based on the diagnosis, it is essential to project the preventive-suicidological competency based on the knowledge, skills, values, and assessments that support this process. Therefore, this subsystem is defined as the process of theoretical articulation to structure the competency, based on the contextual problems that manifest in PHC and that are linked to the professional problems, the necessary content, and the professional disposition for preventive-suicidological management of the MGI. This enables the GBT to advise and monitor the suicide prevention offered, in accordance with the demands of the profession.

Contextualizing IS in relation to professional problems is the starting point for structuring the proposed preventive-suicidological competency, but achieving this requires planning a training process with the intention of GBT, to transform this health damage in PHC, by converting each care action into a training act.

The contents are restructured in the training activities where the determination of knowledge (knowledge), know-how (skills) and being (attitudes and professional values) are specified, which are integrated into the system of contents of suicide prevention, in turn derived from these contents, the essential theoretical and methodological knowledge of suicidology and medical sciences are specified, which allow the enhancement of competence and in correspondence to this, the skills and professional values required for suicide prevention are determined. (5)

All these contents are based on the training cycles of the undergraduate subjects that make up the Main Integrative Discipline (DPI) General Medicine from the subjects of Health Prevention, MGI, Pediatrics, Psychiatry, Public Health, MGI Internship and what other subjects such as Psychology and the modules and/or courses of the specialization can contribute, aspects systematized by the authors, (6) that shape the professional skills required and the values that prepare the MGI, from working the contents in the various modalities of education at work, which allow managing the preventive suicide process with quality, however, this training process still needs to be strengthened, taking into account the previous knowledge of the professional in the initial diagnosis and restructuring the content of suicide prevention as an integrating axis of all training actions, energized by the clinical epidemiological method, the project method and the active methods of teaching, to turn the MGI into a true promoter and preventer of IS in the APS.

Other studies (1,6) agree with the opinion of the research team that the topics of IS prevention are rarely addressed in methodological meetings and in the professional development plan of health units, and very rarely are presented in clinical epidemiological meetings on health situations of suicide attempt or in GBT meetings.

There is sufficient research that has pointed to the high number of suicide attempts in various age groups, with a predominance in older adults (7,8) and adolescents (9-11), and an epidemiological situation that requires better training of family physicians to investigate and care for the most vulnerable risk groups with good dispensation.

Other research (12-14) highlights the importance of preparing the physician in good dispensarization, which includes the patient with ideation or at risk who has not yet attempted suicide and the actual suicide attempt, because it is the only way to carry out specific actions to modify the condition and avoid moving from desires for death and suicidal ideation to increasing behavioral gradation (threats, gestures, attempts and completed suicide).

As various authors distinguish, (14,15) in correspondence with the present study, there is evidence that alerts to the need to continue empowering the MGI specialist in diagnostic tools for better use of suicide promotion and prevention actions. This would favor a more complete

approach to the population at risk if these professionals made better use of the valuable information in the HCI and HSF.

Based on the results that are now being shared in this article and in a consulted work, (15) the urgent need to develop preventive competencies in suicide is evident, given that there is no evidence of the skills of the MGI specialist in the use of social communication techniques (interviews, educational talks, group dynamics and family intervention) that limit a comprehensive assessment of the health, family, and socio-community context, where a legal and biological approach predominates, limiting its modes of action and this transcends to the lack of quality in the attention to population groups at risk.

In a shared opinion, the research team aims to overcome the barriers and weaknesses in the MGI training by working from a novel perspective of the teaching-learning process of the contents of transformative suicide prevention in the context of the APS, by taking as a path the professional improvement every time that everything projected is put into pedagogical practice, tending to achieve the apprehension of the knowledge that will be intended in another phase of the study, by achieving cohesion in the use of the clinical epidemiological method and the active methods of the teaching-learning process, because in the training process of the professional of medical sciences it is necessary to link the object of the profession and the use of the necessary methods to stimulate learning that allows to influence the modes of action expected from the development of competences that affect a successful performance. (1,15,16)

The ultimate goal of developing preventive-suicidological competence is to achieve the deployment of personality qualities and the use of metacognitive processes that enable them to manage the preventive process, the development of positive professional attitudes to undertake the transformation of IS as a contextual problem in APS, aspects to be noted in the development of their skills, abilities, capacities, to achieve the specialized mode of action, based on the adequate understanding of the theoretical-methodological support of suicide prevention, which expresses personalized reflection, initiative, perseverance, autonomy, during the process that manages in the care context, with a positive and persevering disposition in the search for solutions to the authors' criteria.

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Conclusions

In this study, the preventive-suicidological competence of the Comprehensive General Medicine specialist in Primary Health Care is projected as a pedagogical construct.to channel an effective treatment that conditions its successful performance.

Bibliographic references

1. Aguilar-Hernández I, Sanabria-Ramos G, Castañeda-Abascal I, Perera-Milian L. Evaluation of the implementation of the National Program for the Prevention and Care of Suicidal Behavior. Medimay [Internet]. 2019 [cited 31 Mar 2024]; 26 (3): [approx. 13 p.]. Available from:https://revcmhabana.sld.cu/index.php/rcmh/article/view/1484.

2. González Sábado RI, Rodríguez Domínguez LA, González Iturbe F, Smith Hernández MS, Lastres Fonseca L. Self-esteem problems and depression: possible risk factors for suicide attempts. RM [Internet]. 2020 [cited 27 Mar 2025]; 24. Available from:https://revmultimed.sld.cu/index.php/mtm/article/view/1860.

3. González Sábado RI, Martínez Cárdenas A. Competence and performance of family physicians in the prevention of suicidal behavior at the community level. RM [Internet] 2020, [cited 31 Mar 2024]; 24(5). Available at:http://www.revmultimed.sld.cu/index.php/mtm/aticle/view/2024.

4. González Sábado RI, Martínez Cárdenas A, Izaguirre Remón CR. An approach to the need to develop a specific competency of the family physician in the prevention of suicidal behavior. Caribbean Journal of Social Sciences [Internet] 2021 [cited 31 Mar 2024]; 10(7): 85-105. Available from:https://www.revistacaribena.com/ojs/index.php/rccs/article/view/2384/1904.

5. González Sábado RI, Martínez Cárdenas A, Izaguirre Remon RC. Professional training of the specialist in Comprehensive General Medicine and their competence to prevent suicide. Edumecentro [Internet]. 2022 [cited 27 Mar 2025]; 14. Available at:https://revedumecentro.sld.cu/index.php/edumc/article/view/2178.

6. Martínez Cárdenas A, González Sábado RI, Tabernilla Guerra O, Domínguez Morales W, Reytor Ballester D. Student satisfaction with the "Prevention of Suicidal Behavior" manual in Comprehensive General Medicine. Edumecentro [Internet]. 2021 [cited 27 Mar 2025]; 13(3). Available from:https://revedumecentro.sld.cu/index.php/edumc/article/view/1752.

7. Carmona Penton CR, Dreke Núñez A, Leiva Balzaga Y, González Lastre M, Plaín Pazos C, Santana Hernández M. Effectiveness of an educational intervention targeting older adults at risk of suicide. Rev cuba med gen integr [Internet]. 2021 [cited 31 Mar 2025]; 37(4): e1742. Available from:https://revmgi.sld.cu/index.php/mgi/article/view/1742.

8. Ayala Escudero A, Hernández Rincon EH, Avella Pérez LP, del Mar Moreno-Gómez M. The role of the family physician in the primary and secondary prevention of depression in older adults. Rev Medicina de Familia. SEMERGEN. [Internet] 2020. [cited 12 Oct 2024]; 47(2): 114–121. Available from:https://doi.org/10.1016/j.semerg.2020.09.009.

9. Mateus Mora SL, Hernández Rincón EH, Liliana Jaimes C. Primary and secondary suicide prevention in adolescents from a family medicine perspective. FMC. [Internet] 2020. [cited 12 Oct 2024]; 28(10):551-559. Available in:https://www.fmc.es/es-prevencion-primaria-secundaria-del-suicidio-articulo-S113420722100195X.

10. Ruiz Arzayuz HY, Castro Valles A. Motivational predisposition to suicide attempt in outpatient adolescent patients. Iztacala Electronic Journal of Psychology. [Internet] 2021. [cited 1/12/2025]; 24(3): 996-1023. Available at:www.iztacala.unam.mx/carreras/psicologia/psiclin.

11. Figueredo Acosta H. Educational intervention for the prevention of suicidal behavior in adolescents and young people. Rev Cubana Med Milit [Internet].2020 [cited 1 Apr 2025]; 49(3): e0200505. Available from:https://revmedmilitar.sld.cu/index.php/mil/article/view/505.

12. Ellis Yard ML, Reyes Millán PE, Luis Rodríguez MJ. Depression and suicide attempt in an older adult. Case report. Rev Med Elect [Internet]. 2021 [cited 14 Jan 2025]; 27: e1982. Available from:https://revmediciego.sld.cu/index.php/mediciego/article/view/1982/3726.

13. González-Sábado R, Izaguirre-Remón R. Evaluation of the preventive-suicidological competence of the Comprehensive General Medicine specialist. Journal of the Psychiatric

Hospital of Havana [Internet]. 2024 [cited 31 Mar 2024]; 21(1). Available from:https://revhph.sld.cu/index.php/hph/article/view/452.

14. González Sábado R, Martínez Cárdenas A, Domínguez Morales W, Garcia Rodriguez YI. An approach to understanding the presence of neurobiological and psychosocial markers in the genesis of suicide. RM [Internet]. 2021 [cited 1 Apr 2025]; 25(2). Available from:https://revmultimed.sld.cu/index.php/mtm/article/view/1981.

15. González Noyola Ll, Riol Hernández M, Sánchez Alfaro L. The preparation of specialists in General MedicineComprehensive suicide prevention in older adults. Education and Society [Internet]. 2023 [cited 11 Jan 2025]; 21(2): 110-127. Available at:https://revistas.unica.cu/index.php/edusoc/article/view/3362/4678.

16. Escobar Yéndez N, Tamayo Escobar O, García Olivera T. Approaching professional competency-based training in the subjects of Clinical Propaedeutics and Internal Medicine. Higher Medical Education [Internet]. 2022 [cited 31 Mar 2024]; 36(1). Available at:https://ems.sld.cu/index.php/ems/article/view/3252.

Conflict of interest

The authors declare no conflict of interest.

Authorship contribution

Data curation, research, and project management: Rita Irma González Sábado

Formal analysis: Roberto Hernández Álvarez.

Methodology: Rita Irma González Sábado and Rafael Claudio Izaguirre Remón.

Visualization: Osbel Martínez González.

Writing - initial draft: Rita Irma González Sábado and Roberto Hernández Álvarez.

Writing - review and editing: Rita Irma González Sábado and Osbel Martínez González.