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Journal of General Medicine and Clinical Practice
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Open Access

Research Article

Emotional Geographic Atlas O The General Practitioner

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Received date: January 13, 2026; Accepted date: January 30, 2026; Published date: February 12, 2026

Citation: Jose L. Turabian, (2026), Emotional Geographic Atlas O The General Practitioner, *J. General Medicine and Clinical Practice,* 9(3); **DOI:10.31579/2639-4162/331**

Abstract

The general practitioner's emotional perception of their patients is an emotional countertransference. "Mapping" these countertransference emotions would involve a systematic recording of these responses (empathy, frustration, sadness, joy, exhaustion, etc.). Emotions can be represented by a geographical metaphor (mountains, volcanoes, rivers, valleys, islands, waterfalls, glaciers, fjords, estuaries, etc.): using geographical terminology to describe the physician's perception of a patient's emotional or physical complexity in a descriptive way. In this way, an emotional geographic atlas of the general practitioner would be obtained, or more rigorously, a metageographic atlas (beyond geography; a starting point for the physician's reflection on their emotions) of the general practitioner's emotional countertransference. The conceptual bases of this atlas would be: 1) The concept of diagnosis in general medicine: the totality of a landscape; 2) Emotions and emotional diagnosis; 3) Metaphors (images that accurately depict human emotional behavior are difficult to access, making metaphors necessary to understand the unknown in terms of something more familiar); 4) “Affective landscapes” (a landscape is a journey from the inside out and back again: from emotion to landscape and back to emotion); and 5) Narrative landscapes and reflective narratives (narrative is a human capacity that allows us to reflect on significant experiences). Therefore, this atlas would be a fascinating and indispensable conceptual and visual tool for a holistic understanding of the patient.

Kew Words: medical education; narrative; teaching; physician-patient relations; countertransference (psychology); emotions; metaphor; cultural landscape; general practitioner

Introduction

The doctor and patient maintain an interactive relationship, both conscious and unconscious: the patient is influenced by the doctor and vice versa. The psychological phenomena of the doctor-patient relationship influence the therapeutic process. The general practitioner's emotional perception of their patient is an emotional countertransference. Countertransference refers to the set of feelings, attitudes, thoughts, and emotions that the doctor experiences in response to the patient; that is, it is the set of the doctor's emotional reactions toward the patient [1-4].

"Mapping" these countertransference emotions would involve a systematic recording of these responses. Emotions can have a geographical metaphor: using geographical terminology to describe the doctor's perception of a patient's emotional or physical complexity in a descriptive way. In this way, an emotional geographic atlas of the general practitioner would be obtained, or more rigorously, a Metageographic Atlas of the General Practitioner's Emotional Countertransference; this atlas would be a fascinating conceptual and visual tool.

The concept of "metageography," etymologically, refers to an object situated beyond geography. The geographical metaphor of an emotion generates another geography or metageography (5) that proposes a new intelligibility, providing a starting point where the physician's reflective attitude toward their emotions in their professional tasks is presented as an indispensable attribute for understanding the patient in their entirety; it allows for the construction of knowledge that clarifies the doctor-patient relationship. In this atlas, the landscape or geographical feature evoked would be a pretext for expressing the inner world of the doctor-patient encounter. The landscape is not only what surrounds us, but also the reflection that the doctor-patient relationship generates in the professional; it activates our memory. It is in the landscape where we sometimes feel a spark, a luminous fullness [6].

These would not be objective maps in the traditional sense, but rather a collection of subjective representations or clinical stories/vignettes that would help physicians recognize, understand, and manage their own emotional responses during daily clinical practice. This atlas would serve as a self-awareness manual, using geographical terminology to give shape and

structure to the general practitioner's emotional reactions. As was common practice in old maps, which prioritized cultural representation over geometric accuracy, often distorting shapes to increase information density [7, 8], the maps in the “emotional geographic atlas of the general practitioner” would prioritize the emotional aspect over precise geographical detail. Each “map” would represent a specific type of clinical encounter or a recurring emotion.

There is precedent for the idea of creating atlases of emotions. Two Dutch cartographers, Jean Klare and Louise van Swaaij, published a simplified version of an “Atlas of Experience” in 1997. Later, these authors developed a whole world of maps reflecting human life experience and emotions [9]. The maps of an “emotional geographic atlas of the general practitioner” would be clinical landscapes or vignettes that present emotional situations such as empathy, frustration, sadness, joy, exhaustion, etc., described and visualized metaphorically as emotional landscapes (which can have emotional, cultural, and spiritual significance for individuals, evoking feelings of peace, beauty, nostalgia, or belonging) [10]: mountains, volcanoes, rivers, valleys, islands, waterfalls, glaciers, fjords, estuaries, etc. [11, 12], which general practitioners experience when dealing with different clinical cases and patients, with the aim of better understanding who we are and what we do as physicians in relation to our patients.

However, texts about the emotions of doctors in their practical work are scarce. In this context, a theoretical study is presented that explores the conceptual foundations of an “emotional geographic atlas of the general practitioner” and encourages further exploration of this concept. The ultimate goal of such an atlas is to expand our collective memory; to recall what illuminates our experiences in our consultations as general practitioners and to serve as a teaching and learning tool.

Methodology

This article is a personal viewpoint; it aims to reflect on, conceptualize, and propose, based on a selected narrative review and the author's experience, the teaching-learning tool called "emotional geographic atlas of the general practitioner."

Discussion

The conceptual foundations of an “emotional geographic atlas of the general practitioner,” as explained in the Introduction, would be:

1. The concept of diagnosis in general medicine: the totality of a landscape

The diagnostic process is a mental operation through which the pathology is identified and the illness is evaluated [13]. In medical school, one learns to see the “figures of the landscape”—the current presentation of the symptom—and to disregard the context. But in general, /family medicine, it is crucial to first perceive “the background of the landscape.” The complexity of general medicine lies in contextualizing medical care for each patient. The episode of illness is part of the totality of a landscape [14-18].

Throughout a person's life, illness appears between the individual and their relational context. The patient does not have an illness; rather, they create their illness [19, 20]. General practitioners are trained to work with pathologies, but in their consultations they encounter symptoms—chest pain, fatigue, dizziness, etc.—that appear to have biological causes, but in most cases these are predominantly psychosocial rather than biological in origin: 60% of abdominal pain and 80% of chest pain are non-organic. At least a third of symptoms lack a clear organic basis. The idea that patients visit doctors for physical reasons stems from hospital ward experience and must be discarded in general practice. Clinical categorizations based on the mind-body dichotomy often lead to attempts to rule out organic causes before pursuing a therapeutic approach, with the consequent risk of false-positive results, increased patient anxiety, and reinforcement of the physical symptom-consultation-diagnostic test cycle [21-23].

Often, the presentation of the problem can be taken for the whole picture, without being able to delve into its underlying meanings. The biopsychosocial perspective on the reason for consultation represents a sudden evolution, a leap. Separate parts come together. The result is surprising. This also implies that the medical history provides substantially more information than the physical examination, so it would be advisable for the general practitioner to dedicate more time to the medical history or careful clinical interview than to the physical examination, which could be briefer and focused on the main aspects [19, 20]. Of course, the medical history is not the whole picture, and the physical examination is nothing; but the medical history is almost the whole picture, and the physical examination is almost nothing. The scope of the medical history is extremely important. It informs us about the dependence of the functional disturbance on internal and external circumstances. Through it, we learn about the patient's suffering, what it means to them, what their being is, their state in the world. It will never be possible to overemphasize these concepts in the assessment and treatment of the patient.

2. Emotions and Emotional Diagnosis

Emotions are a fundamental part of the doctor-patient relationship. They affect both patients and doctors, and both can suffer their effects. The traditional Western view, dating back to Plato, is that emotions are an obstacle to intelligent action. However, there is also the opposite view. Intelligent actions result from the harmonious combination of emotion and reason. Organisms without emotions are less rational than human beings. Knowing when to follow our feelings and when to ignore them is what constitutes "emotional intelligence." Emotions are allies, not enemies of reason. There is a common misconception that feelings are subjective and confusing and therefore should not be part of logical and objective thought. This is completely absurd. In the end, it is our feelings that give value to the fruit of our thinking.Emotions have a bad reputation in medicine. The dangers of emotional involvement are emphasized, but not those of the absence of emotions. Emotional maturity is considered to consist of the absence of emotions (or forgetting emotions and hoping they disappear) rather than possessing the necessary skills to express them appropriately. There is more talk about controlling emotions than about fostering them. It is said that one must be "objective" and fair, not subjective and emotional. Furthermore, emotions are often included in lists of signs and symptoms of mental illness, but nothing is said about them being signs of mental health [24-26]. In most decision-making contexts, people must choose between possible outcomes. which they have not yet experienced. Therefore, they must consider the possible consequences of different outcomes to select the most appropriate option. However, it is important to note that relevant consequences can include not only physical or financial results, but also emotional ones. Consequently, people often make affective predictions, anticipating their emotional reactions to future events [27].

Effective communication is said to be 20% what we know and 80% how we feel about what we know. Examples of feelings in a doctor toward a patient include: overwhelm, paternalism, helplessness, insecurity, rejection, arrogance, perplexity, etc.; and in a patient: impatience, frustration, guilt, distrust, submission, fear, complicity, shame, indignation, arrogance, incomprehension... A positive way to view emotions is as resources and opportunities in patient care. In people management, cognitive aspects alone (knowledge, competencies, and skills) do not enable the development of innovation. Rather, attitudes, emotions, and motivations must be taken into account [28-32] Ultimately, all decisions are emotional. The purpose of reflecting on decision-making is to help ensure our emotional reaction is

channeled constructively: objective, emotionless decisions simply don't exist. The issue of emotions and interpersonal relationships cannot be ignored in clinical practice. How doctors and patients feel in their daily experiences at the health center/hospital is crucial for the work to run smoothly. Although no one can ever have complete control over their feelings, when we use them positively, we improve our clinical practice.

3. Metaphors

We can hardly access images that depict emotional behavior in human beings, so it is necessary—both individually and collectively—to investigate this information. This atlas explores the emotional reactions of general practitioners through landscapes/geographical features. The objective is to create environments into which the viewer/reader is drawn, evoking spatial and emotional sensations. The reader, the viewer, moves through, observes, is enveloped by the atmosphere, and finds themselves immersed in the emotion [33].

Metaphors allow us to understand something unknown in terms of something more familiar. This is why they are a common resource in all sciences, which use everyday words to name complex realities. The analogy between a particular phenomenon observed in a certain artistic or scientific field and a particular phenomenon yet to be understood and observed in general medicine provides important support for understanding the latter in our profession. Metaphors are analogical devices for illuminating reality. Metaphors (which include analogies, similes, and models) are cognitive tools by which something unknown is understood in terms of something known [(34]. Words and things are not the same, and therefore, to re-establish a precarious unity between humankind and the world, things are named with images, rhythms, symbols, and comparisons. Words are not things; they are the bridges we have between them and ourselves [35].

Metaphors can be keys that open and unlock doors that stand between holistic care and patients. Metaphors are important ways of expressing the meaning of language and illustrating imaginative thinking for healthcare disciplines. The meaning of metaphor from a human-becoming perspective includes three elements: semantic resonance, coherent integrity, and magical transfiguration. Metaphor is a linguistic way of conveying an idea in poetic language with words. Mental metaphors can be strategically activated to improve word learning (36). The metaphor—transfer, transposition—etymologically indicates the position of one thing in place of another to make expert thinking about clinical reasoning accessible. Metaphors simplify knowledge, not to ignore or reduce inherent complexity, but to provide an entry point into its understanding, generate ideas, foster creativity, and build concepts and theories. Here, general practitioners can use the techniques of architects who work with analogies, symbols, and images, obtaining unexpected ideas and stimuli. Thinking in metaphors, in comparisons, is a way to convey a concept in a suggestive, interesting, and surprising way, which can reach people more easily [37, 38].

4. "Affective Landscapes"

In this atlas, the landscape/geographical feature serves as a pretext for expressing the physician's inner world. The landscape is not only what surrounds us, but also the reflection that this space generates within us; the landscape activates our memory. It is in the landscape that we sometimes feel a spark, a luminous fullness. The landscape is a journey from the inside out and back again: from emotion to landscape and back to emotion [6].

Some landscapes can transport us to a distant place and tell us a story without words. Narrative landscapes invite us to explore magical and evocative places, where each element tells a story on its own. Whether a forest or a raging sea, these landscapes invite us to create our own narrative and immerse ourselves in worlds of fantasy. Landscapes can also capture emotions and feelings in a single image.

The landscape emerges from the effort of those who travel its paths, slopes, plains, or inclines, and is, therefore, a "construction of fatigue," of repeatedly attending to patients. Thinking about landscape is both an expression and a part of the experience of practicing as a general practitioner; it is a constant exercise in emotion and reason, the deep heartbeat of a listening heart. In this view, the landscape is an encounter that gives us a measure of who we are and intimately defines us. This image of the landscape underscores a shared emergence of the world and the individual. In this intimate dialogue between the individual and the landscape, there is an attempt to defend life from the "disenchantment" brought about by the rationalization and technification inherent in modern medicine, and a need to seek, once again, new sources of "the mysterious." The landscape is defined by the individual's participation in an adventure without which the world is reduced to a sterile surface devoid of meaning. The landscape is a place of emotions and an exercise of the heart. Here, the landscape reveals itself as an illumination, as a supreme moment of understanding and apprehension of the world, the instant in which we have access to meaning. Interest in the affective dimensions of landscape or geographical experience is part of a broader movement in contemporary thought toward the revaluation of subjectivity and the integration of emotional components into the process of knowledge and personal development. On the one hand, there is a search for understanding emotions and their formation, location, materialization, and reproduction in specific spaces. On the other hand, the opposite dimension is simultaneously explored: how space is emotionally constructed.

The aim is to integrate landscape and space as a central element of the very structure of experience, as another part of the fabric in which we are embedded and which shapes our identity: the walk in the woods, the ascent of the mountain, the rest at the foot of the cliffs, the contemplation of the valleys, and so on. Each of these moments and emotions weaves the relationship between the subject and the landscape. "Affective landscapes" are fundamentally defined by a "resonance," a kind of echo or (bidirectional) flow in which the landscape activates a strong evocation in the individual, and the individual, in turn, manages to "make the landscape speak." In a way, "affective landscapes" are the geographical expression and the material and symbolic embodiment of our affections. It is a geography of small emotions and small gestures, but one that has the breath of great feats [39].

5. Narrative Landscapes and Reflective Narratives

The clinical vignettes represent a labyrinth that the reader must navigate, concentrating at each new door without speculating about the exit; constantly in a decision-making situation; being "awake" [6]. Stories are an integral part of everyday life, and in medicine and medical education, a wide range of stories are told daily [40]. Narrative is a natural human capacity that allows people to reflect on significant experiences. This is evident in various professional fields, including healthcare, where reflective narratives constitute a rich source of data for qualitative analysis, offering insights into complex interpersonal dynamics and professional development. Reflective narrative writing creates a space for students to contemplate their experiences, organize thoughts and feelings about themselves, others, and clinical events, as well as helping them cope with intense emotions and guide their future behavior. The importance of writing and analyzing narratives is particularly relevant in medical education, where narratives reveal insights into experiences and understanding of the hidden curriculum (i.e., informal norms and rules within the clinical setting).

These reflective narratives presented in this atlas could have diverse content (e.g., on prototypical consultations, critical incidents related to

professionalism, delivering bad news, etc.). Narratives are known for their ability to engage audiences more deeply than non-narrative message formats, thanks to their capacity to transport the audience into the plot and connect them with its characters. The audience's deep emotional connection with the content and characters of the story could allow them to experience a specific professional event. Furthermore, the characters in the maps/lanscapes/stories/cases or clinical vignettes can serve as schematic models commonly encountered in general medical practice, allowing for indirect learning through their actions [27].

Thus, this atlas would be a collection of descriptive clinical vignettes, like the plates of a geographical atlas, depicting the different emotional landscapes that general practitioners experience in their consultations with various patients. The set of clinical vignettes unfolds like a map, allowing the reader to reconstruct a journey.

The clinical vignettes will present emotional situations such as Admiration, Afraid, Alertness, Anger, Anguish, Anxiety, Arrogance, Block, Burnout, Calm, Caution, Compassion. Concern, Confidence, Confusion, Contentment, Despair, Dependency, Determination, Difficulty, Disappointment, Discomfort, Disconsolation, Disorder, Displeasure, Distress, Distrust, Duress, Emotional exhaustion, Empathy, Enthusiasm, Euphoria, Exasperation, Expectation, Fear, Frustration, Gratitude, Grief, Guilt, etc., described and visualized metaphorically as emotional landscapes (which can have emotional, cultural, and spiritual significance for individuals, evoking feelings of peace, beauty, nostalgia, or belonging) [10]: archipelago, atoll, bog, cave network, comet, cove, deforestation, delta, desert, disorganized storm, dune, earthquake effects, estuary, fiord, floodplain, flowering desert, forest, glacier, gorge, gully, gusts, harbour, headland, jungle, lake without waves, lava, mountain, moor, narrow strip of land, oasis, pot-hole, quicksand, etc., that general practitioners experience when dealing with different clinical cases and patients, with the aim of better understanding who we are and what we do as physicians in relation to our patients [41-50] In summary, Metageographic Atlas of Emotional Countertransference in the General Practitioner would be a fascinating conceptual and visual tool for educational and therapeutic purposes.

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DOI:10.31579/2639-4162/331