

### From the bond to the caring encounter: cartographs about medical identity territory and the care between family doctors and users

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Del vínculo al encuentro cuidador: cartografías sobre el territorio de identidad médico y el cuidado entre médicos de familia y usuarios (resumen: p. 16)

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The purpose of this qualitative research with a cartographic approach was to understand the effects that bonding and accountability between family physicians and users can produce on the physicians themselves. Ten open interviews were conducted based on triggering questions with family physicians and medical residents. The analysis of the interviews using the reference of the micropolitics was based on the experiences reported, and it was problematized the existence of a "medical identity territory", as well as the deconstruction of this territory, its "deterritorialization", leading to "reterritorializations", such as moving away from omnipotence / infallibility not to suffer, but to take care of oneself and others. It is proposed that in this movement, both physician and user start to move through the caregiving dimension of the encounter, where light technologies can be operated and new possibilities of configurations of care happens.

**Keywords:** Family practice. Continuity of patient care. Bond. Patient-Centered Care.



## Introduction

The Family and Community Medicine movement (FCM) has as one of its proposals within the guiding principles of the specialty, the valorization and strengthening of the doctor-patient relationship<sup>1</sup>. For this purpose, the proposal of a Person-Centered Clinical Method (PCCM) is highlighted, placing the interaction between doctor and patient as a central focus, taking into consideration the particularities of those involved as well as allowing the patient to have a leading role in this relationship<sup>2</sup>. As proposed by McWhinney<sup>1</sup>, the family doctor should aim to know the person before getting to know the disease, which means that it is necessary to make use of resources usually used in interpersonal relationships, with their subjective and immeasurable aspects, such as intuition, empathy, one's emotions and those of the other. For the purposes of this article, we will call these relational technologies as "light technologies", as presented below<sup>3,4</sup>.

The longitudinal character of the care that the doctor offers at individual, family and community level is of great importance in building the relationship between family doctor and user. Longitudinality is defined as the subject follow-up over time for diagnostic, therapeutic and preventive purposes, and is one of the essential attributes of Primary Health Care (PHC)<sup>5</sup>. This continuous follow-up allows multiple encounters between doctors and users, generating opportunities to deepen the understanding of the subject's characteristics, therefore understanding that a person's numerous illnesses only make sense when recognized in his/her personal, family and community context<sup>6</sup>. And, more than this, it is capable of producing a bond - a connection - between family doctor and user, a bond that emerges and is maintained in the interaction that happens in each encounter between these actors, generating diverse feelings in both, and strengthening the connection between them<sup>6,7</sup>.

The concept of bond appears in documents related to Primary Care in Brazil as an instrument operating upon the coexistence among the subjects and with potential to confront health issues and keeping people healthy<sup>8,9</sup>. It is also understood as an essential factor in building relationships of trust and closeness between users and health workers, stimulating co-responsibility and intensifying the therapeutic potential of health encounters<sup>10</sup>. In a review<sup>11</sup> with regards to bonding in health care in Brazil, it is depicted the deepening of the understanding of the population's health problems, attended by the professionals linked to them, which would motivate them to develop a joint effort in search of solutions, facilitating the relationship between users and professionals.

Regarding the encounter between doctors and users, the contact between these actors in the health production proposal may constitute an intercessor meeting, in the sense of allowing the emergence of a singular process, a product that is done in act, an intercessor space that will only exist in these meetings<sup>3,4</sup>. In Merhy's words<sup>4</sup>:

the image of this space is similar to that of the construction of a common space, in which one intervenes over the other, and for this reason it is characterized as an intercessor process and not a simple intersection, since it contains in its constitutivity the logic of mutual production in a micropolitical act, which supposes the production of one in the other. (p. 173)



In this field, the technological dimensions of care may be operated through hard, and light technologies, but especially the latter<sup>3,4</sup>. Hard and light-hard technologies constitute the hegemonic modalities, which include professional-centered actions through more invasive interventions, dependent on equipment and material resources (hard technologies), or specialized knowledge and strictly protocolized interventions (light-hard). Light technologies are the technologies of relationships, and can be exemplified by the production of bonds, stimulation of autonomy, embracement and management as a way of organizing work processes in the sense of producing care. In their proposal, they bring a collective way of building configurations of care with user-centered health care, and consequent shared construction of care<sup>3,4</sup>.

Most studies on the quantitative aspects of the physician-user relationship in the context of PHC show an increase in the satisfaction of users who are accompanied longitudinally by a reference family doctor<sup>12-14</sup>. Additionally, it has been described that the bond and continuity in the follow-up of users can produce in the family doctor a higher sense of responsibility for those people and professional satisfaction, while other studies also show feelings such as the strengthening of the sense of competence, but also emotional wear and tear due to difficulties in diagnosis and the relationship with demanding users, which can lead to psychological exhaustion and even burnout syndrome<sup>15,16</sup>.

Over a half of the physicians suffer or have suffered from symptoms related to professional exhaustion, and in family doctors the prevalence can reach 60%<sup>17,18</sup>. Among the main factors that trigger or aggravate this burnout in doctors, are worth of note the following: the inadequacies of work processes; overload; limitations and ambiguity in the performance of roles; emotionally fraught consultations, among others<sup>19</sup>. On the other hand, factors such as a good relationship with users and feeling recognized and valued for their work are related to the feeling of professional satisfaction, and therefore can protect the doctor against the physical and psychological effects of long-term stress. Moreover, when stress takes precedence over professional satisfaction, the risk of exhaustion is considerably increased<sup>17,19</sup>. What, then, would be the role of bonding in producing stressful or rewarding feelings for family doctors experiencing a longitudinal relationship of care for their users? Would the bond itself be a factor in the generation of overload, as the doctor intensifies the relationship with the user and feels responsible for the person's health outcomes? Or could the therapeutic and satisfying potential that the bond has for the user be extrapolated to the doctor as well?

This research, linked to the Family Health Professional Master's Program (ProfSaúde), promoted by the Brazilian Association of Collective Health (ABRASCO) and Brazilian teaching and research institutions, aimed to understand the effects that bonding and responsibility between family doctors and users can produce on doctors themselves. Its constructive process was conducted from the perspective of the micro-politics of care and work in health. Throughout the fieldwork, an opening was made to new issues pointed out by the empirical findings (such as, for example, the existence of a medical identity territory and the possibilities of restructuring this territory from the experiences allowed by the bond with the user). This dynamic character of the study



was in conformity with the methodological strategy chosen, the cartographic approach, which allows the researchers to be immersed in the field of research therefore producing knowledge through the affections and intercessions brought about by the encounter between researcher and researcher<sup>20,21</sup>.

## Methodology

It is an exploratory study with a qualitative approach and cartographic orientation. Ten open interviews with trigger questions (Frame 1) were conducted with family physicians working at PHC in Curitiba, state of Paraná and doctors undergoing the FCM residence at the Federal University of Paraná (UFPR) who had been working for a year or more in the same community, to ensure a minimum degree of longitudinality required for the development of the study. The choice of participants was made by appointment among professionals from these institutions, with an individual invitation made by the researchers, intentionally choosing those professionals who were described by their peers as having a close relationship with their users and community. Physicians from three different groups were interviewed, according to the criteria of time spent working in PHC: I) Residents with two or three years of FCM practice; II) young physicians with up to 15 years of work in PHC; and III) experienced physicians with more than 30 years of professional activity. Such classification of participants was considered in the research as necessary for an evaluation dependent on some degree of longitudinality, and allowed access to different opinions and experiences.

**Frame 1.** Trigger questions for open interviews.

In your clinical experience, engaging in relationships with users and families:

- How would you describe the emotional effects on yourself when you develop a closer relationship with your users over time?
- Have you experienced rewarding effects from these relationships?
- Additionally, were there also stressful, paralyzing, frustrating effects...?
- Tell us about the meaning that these effects presently have or have had for you?
- Would you like to tell us about a remarkable situation for you?

Source: Authors (2018).

The interviews took place between January and October 2018, after obtaining informed consent from the participants. They were conducted individually (a researcher interviewed a participant at each meeting), in environments chosen by the participants, where confidentiality and privacy of information could be guaranteed (for example: participant's office, University meeting room, participant's residence). The material obtained in the interviews was analyzed by the researchers from the perspective of the cartographic approach, which proposes to value processes of subjectivation in the field of research, allowing for the collection of information no longer to be restricted to the domain of representation, therefore allowing for an analysis procedure in which reality is to be studied in constant transformation and movement, a reality composed



of different narratives, contexts and lines of force to be considered in its complexity and uniqueness<sup>20,21</sup>. Based on the reference of micropolitics, we sought to access the experiences the way they were lived by the participants, and in the intercessor encounters between researchers and interviewees we sought to allow different possibilities of subjectivation and singularization, in addition to exchanging knowledge, and doing so in a process that included the pedagogical dimension<sup>22</sup>. In this manner, it became possible to map not only the subjectivity of the other, but also affections and mutual transformations, including those of the researchers, and the product of this cartography was extensively recorded in field diaries.

During the progress of the research, some preliminary analyses of the empirical material showed, as we will see in the next section, a codification defined by a certain “medical being”, demanding the use of another concept and tool of the micropolitics reference frame: the “identity or existential territory”<sup>23,24</sup>. This concept had already been used in previous research<sup>25</sup> to understand how historical-social repetitions of discursive sets produce a normative body for acting/living, sets that are composed of significant referents (in that research “to be a health professional”) and transcendent values (in this research “how the health professional should be and act”)<sup>23,24</sup>. The concept of existential identity or self-referenced territory is based on the assumption that the significance of communication, not dissociating expression and content, is involved in processes of subjectivation<sup>23-25</sup>.

If speaking about an identity, or acting according to it brings it to existence, the de-constitution of this identity territory can also happen through “deterritorializations”, or exits to other meanings, totally or partially changing the limits of the current identity in the sense of new “re-territorializations”<sup>24</sup>. It should be added that the principal researcher/author is a family and community doctor, in full professional activity during the course of her research field work, and that, since she is undergoing studies to obtain a professional master’s degree, she experienced by herself the daily situations and feelings very similar to those she was investigating.

This study was approved by the Research Ethics Committee (CAAE nº78685517.3.0000.0102).

## Results and discussion

Ten physicians were interviewed, four of them resident physicians (MR) up to 29 years old; three “young physicians” (MJ) aged between 31 and 37 years; and three experienced physicians (ME) aged between 55 and 62 years. There were four women and six men, having completed their medical training in periods ranging from 2 to 36 years, and working in the health unit during periods from 1 to 18 years. The main researcher, when interviewing colleagues from specialty and work scenarios, although she was not herself interviewed, placed herself at the same time as researcher and research-participant in matters referring to the present analyses, in an inter-place that the cartographic approach allowed her, since “being a doctor” is an existential identity that also constitutes her as a subject.



All the interviewees brought in their statements elements that we relate to a “medical identity territory” or “medical identity”, a set of statements that offer normative values and convictions of behavior whose daily repetition legitimizes their actions as professionals when structuring a belonging to this profession. As examples, we identify expressions such as “the scope of medicine”, “bread and butter of doing medicine”, “being a doctor”, as some of the following passages show:

I feel that it is easier to go beyond and not just do that ‘bread and butter’, this gives a fuller, more intense realization in this part of life, the professional. (Excerpt from the interview with MR3, our emphasis)

It’s a relationship that transcends a bunch the doctor-patient relationship, and it’s been a long time, that we have this kind of relationship... I would say like this, it goes out from the scope of ‘just a doctor’, to worry about people’s lives, me with their lives and them with mine. (Excerpt from the interview with ME1, our emphasis)

The above statements show that the idea of “being a doctor” presupposes a certain code that is concretized in the territory from which the doctors speak and in which they understand themselves: everything that extrapolates such limits would configure a “beyond being a doctor”. Possibly, even before the medical graduation, subjects already carry within themselves the elements that compose such territory, from their life history, culture, beliefs, lived experiences, which orbit around the theme “medicine”<sup>26,27</sup>. The medical identity, therefore, is a construction that is not exclusive to the university education of this professional.

The constitution of what a “medical identity” would be, is expressed in these statements showing that, for the totality of the interviewees, there is an assumption that to exercise this profession it would be necessary to follow a certain way of acting, of being, of thinking. Such concepts bring elements that go back to the origins of medicine, as can be seen, for example, in the philosophy of Avicena, a Persian physician of the Middle Ages who enumerated the many aptitudes expected of those who practiced medicine, such as:

[...] having an acute look, a keen ear, a lucid head and a critical spirit [...] He must be healthy in soul and body [...] He must have a convenient external appearance and good manners<sup>28</sup>. (p. 32)

[...] or in the Hippocratic oath, with its pledge: “I will keep my life and my soul immaculate<sup>26</sup>. (p. 441)

It is in the Middle Ages that “being a doctor” started to be defined in the social context, with the exercise of medicine beginning to be regulated by laws and the need to grant a degree<sup>28</sup>. From that moment on, the figure of the physician has a greater social expression, since the physician bases his practice on methods and techniques based on scientific



knowledge that “belongs” to medicine<sup>28</sup>. The idea of the omnipotent, altruistic doctor, with power over life and death, is moving towards a pronounced idealization of the profession<sup>26-28</sup>. In this sense, most of those interviewed interpret their actions as an exercise of their power as doctors, and recognize that there is a feeling of omnipotence that permeates their professional practice, whether by the attitude of the doctors themselves towards their users, or by the attitude of society or institutions towards the doctor:

You need to decide all the time very important things for those people that may sometimes raise even more serious diseases, life or death. (Excerpt from the interview with MR3, our emphasis)

[...] when you see the patient in a situation of emotional, social suffering, of great hardship, this generates compassion, and at the same time a desire to change and mess with your power, and to be the centralizer of medical power, we have a power over the lives of these people. [...] and this suffering, this pain, when it hurts my ego, this medical ego, the pain of this omnipotent being that we embody as doctors”. (Excerpt from the interview with MJ3, our emphasis)

[...] Today a patient said: “You know, doctor, you don’t even look like you’re a doctor, you do all this and you’re still on the same level as us!” (Excerpt from the interview with ME3, our emphasis)

Jeammet et al.<sup>29</sup> quote aspects of the power relationship between doctors and users, where the former is in a position of “enlightened authority” because she/he is the bearer of knowledge for healing. Maldonado<sup>30</sup> comments regarding the belief that the professionals will only be worthy of respect and trust if they place themselves as strong and omnipotent persons and, more than this, that there would be a desire on the part of doctors to create an aura of mystery about their procedures, adopting an authoritarian conduct with fewer possibilities for questioning. If, on the contrary there is an approach, a caring attitude, then, “it doesn’t even seem like she’s a doctor”, as ME3 quotes.

The idea of omnipotence that is intrinsic to the doctors’ identity territory will not only reflect in their power relations with other subjects, but also in the way doctors see themselves, how they experience feelings such as fear of making a mistake, guilt for a presumed failure, shame for not meeting expectations, or even difficulty in remaining emotionally intact so as not to prove fragile in front of the other, and commit their judgments in face of decisions to be made<sup>31</sup>.

The Code of Hammurabi, Babylonian king of the 18th century B.C., foresaw that the physician who made a wrong diagnosis or treatment should have his hands amputated as a form of punishment for the error<sup>28</sup>. Figuratively, the “amputation” that physicians suffer by understanding that their omnipotence is not as perfect and exact as they believed could lead to a process of deterritorialization: a discontinuation of self-referential territory as proposed by Guattari and Deleuze & Guattari<sup>23,24</sup>. Often, the trigger of deterritorialization can be an experience of loss - either of infallibility or of un-affectability:



[...] we have a power over these people's lives, which can also bring a feeling of powerlessness, because this power is also limited. (Excerpt from the interview with MJ3, our emphasis)

[...] but the patient ended up dying, so... it gave me a... a very bad feeling, a feeling of loss, a feeling of powerlessness, because I saw this patient several times, and regardless of having seen him so many times it seems that it wasn't enough, or: you didn't save his life, you may say, right? (Excerpt from the interview with MR4, our emphasis)

I try not to show the feeling, but I feel! sharing a moment of suffering with the family that is also my suffering too, I already had affection for that patient. (...) And the sadness, the grief... there is a feeling of loss, for an affective matter. But there is a feeling of loss when you see that we have failed... then you feel like the worst doctor in the world, 'right? Because, damned! her death could have been avoided, right? (Excerpt from the interview with ME3, our emphasis)

The bond with the user, in these cases, also produced an opening to another deterritorialization because, besides having to face the reality of her/his own imperfection, there was one more factor producing disturbing feelings: the pain of the other, which from the intercessor<sup>4</sup> meeting, allowed the doctor to look beyond the purely technical or professional. Schultz et al.<sup>16</sup> describe that the bond and continuity of care can produce emotional distress in family doctors, especially when there is frequent contact with the user's suffering, or when attempts to solve such suffering are unsuccessful. Da Silva & Teixeira<sup>31</sup> quote that "the doctor is seen (even by himself) as the one who should know, and if he does not, it is because he is not a good doctor" (p. 6). In the interviews, some doctors reported that the suffering they experienced actually elicited questions about their professional capacity, and even surfaced their desire to give up medicine:

There are cases that always end up being marked, and that for me brought so much anxiety to the point that I questioned my professional capacity, my profession, if I 'was' in the right profession, including thinking about abandoning, leaving this area, going to another one, sometimes until changing profession". (excerpt from the interview with MJ1, our emphasis)

Several authors<sup>17,32-34</sup> comment on the possibility of developing a professional callousness by those who, when trying to deal with instabilities and uncertainties of the profession, understood that the distance from the pain of the other would be a safer path. They took refuge in rationality, in technicalism, in hard and light-hard technologies<sup>4</sup>, as we would say. Some may even experience a kind of depersonalization, emotional indifference, and negative feelings towards users<sup>33</sup>.



Recognizing and analyzing one's own identity territory can be a path to another recognition, and possibly this will happen over the years, as doctors experience different situations that place them confronting cracks in their territory. In fact, most of the doctors who brought to the interview elements of a reconfiguration of existential territory were the MJs (over 31 years old) as well as the "experienced". The resident doctors were less explicit in this sense.

These facts raise some questions: would it still be possible to process, during medical training, the disturbing aspects of medical identity territory, in order to reduce suffering and make possible a widening of this territory, a flexibilization of it providing more satisfaction for both doctors and users, in times of deterritorialization? How to support doctors in the sense of re-territorialization in a territory that is more caring for themselves and the others, in a user-centered perspective?

Some of these points have been worked on in medical residency programs when there is stimulus to the development of communication skills, to the development of bonding, to the recognition of the user as the central object of care, as in PCCM<sup>2,13,32,35</sup>. There are also experiences of encouraging residents and medical specialists to self-knowledge and self-care, through psychotherapy, participation in Balint groups, stimulation of practices that can reduce emotional overload such as contact with art, the exercise of spirituality, or through Integrative and Complementary Practices<sup>18,19,32,34,36</sup>. The interviewees also cited such strategies:

There are other things in the world that make us feel human again, so for example art, art is a means of getting in touch with what is human in us, by watching movies, watching paintings, listening to music, experiencing art, the theater, are tools for us to resignify [suffering]. [...] and when you have some faith, in some paradigm, that explains the whys of life, there is somewhere to hold on". (Excerpt from the interview with MJ3, our emphasis)

[...] something we had already discussed in the residence, about communication, [groups] Balint, I think, by talking you also grow, you understand better, you can work on these issues. (Excerpt from the interview with MR3, our emphasis)

Much more than an effort to get a distance from users, the deterritorialization experienced (and allowed) by the interviewees made possible reconstructions of the medical territory in other configurations, with the production of territories sometimes more caring for themselves and the other. It is when this search to rearrange the existential territory points to a re-territorialization in another place, a displacement to a "caring place"<sup>4</sup>.



[...] this closeness leaves us very vulnerable, right?, that myth of the doctor, the guy who is untouchable, ends. So the chance of criticism and the breaking of expectations towards me is much greater... so I feel more vulnerable in this sense, but this does not weaken me, what gives me support is my technical capacity too, and in this sense I need more and more to be studying, doing negotiations, everything is shared, everything to give me security. [...] (Excerpt from the interview with ME3, our emphasis)

This speech shows the physician's movement towards re-territorialization where recognizing one's vulnerability becomes something acceptable and even desirable. A shift that extrapolates the individual and becomes a collective process is then allowed: another "being a doctor" is possible for both the professional and the user. And the bond, strengthened in the intercessor encounter, is capable of producing in the doctor feelings of satisfaction, fulfillment and belonging. In this process of another recognition of oneself, it is understood that the role of physicians linked to their users transcends possible outcomes that are measured only by hard and light-hard technologies<sup>3,4</sup>:

[...] and that person will live or die regardless of how other people act, these are the rules of the game, and the game 'is' set, we don't own the board, we 'are' just another pawn, we can be a conscious pawn with a lot of potential, with a lot of sense of its potential... we are expendable, we are useless, by accepting this, we manage to be in that place aware of our smallness and with this awareness increases our potential for help, healing and reassurance. (Excerpt from the interview with MJ3, our emphasis)

Caprara & Rodrigues<sup>13</sup> discuss the asymmetrical relationship between physicians and users, in the sense that physicians are holders of the totality of knowledge from which the user is generally excluded. Seixas et al.<sup>7</sup> reinforce the role of the bond in establishing symmetrical relationships, in which the health user is seen as a valid interlocutor, and whose knowledge has equal or greater importance in the construction of care. The position of controller over the life of the other then gives way to a de-territorialization capable of empowering the self-analytical process of care production, deconstructing the figure of the omnipotent physician and producing encounters with symmetry of power.

Especially when we speak of a bond constituted of symmetry of power and knowledge, the deconstruction of the image of the infallible doctor brings with it a reassuring potential. Many interviewees reported feeling more secure because they are linked to users, with less fear of failure and more power in facing problems, while the idealization of the omnipotent doctor is undone:

[...] I am also fallible, I can make mistakes, but the strong bond gives me more security to be able to practice medicine in the best possible way, and also with more peace of mind if I perhaps make mistakes. (Excerpt from the interview with ME3, our emphasis)



Dealing with uncertainty we always deal with, but the bond makes this uncertainty a little easier to manage. (Excerpt from the interview with MJ1, our emphasis)

Moreover, the bond establishes itself as fertile ground for the intercessor encounter to take place and be translated into care, where the subjects give up their position of dominion over the other and give themselves over to a shared construction of care, allowing themselves to reveal their non-knowledge and be affected, not only by suffering and fragility, but especially by the power of life of the other<sup>4,7</sup>. And for the doctor who is daily exposed to the difficulties of the profession, self-knowledge linked to users can play a more invigorating role, rather than an exhausting one. The symmetry that produces bond goes beyond relationships of knowledge and power and becomes a “symmetry of care”: doctors gain potency in acting because they feel bonded to their users, producing new possibilities of care for the other and for themselves, understanding that whoever provides the care can also receive it, in the same act, because it is an intercessor encounter:

[...] but we, those who are in PHC every day with the population, we suffer together. You create bond, you create bond. You suffer together, but that, on the other hand, is the reward that we have, of feeling close. (Excerpt from the interview with ME2, our emphasis)

As we also sometimes feel welcomed by the patient, when the patient sees that we ‘are’ tired, not well, they play the therapeutic role with us, this brings us a feeling of belonging, a feeling of being present in the community, of being human, and being besides a doctor, another person there along with him. [...] then I have to get in touch with myself and remember that a human suffers, accept my failure, accept the failure of the other, accept the pain that ‘is’ in humanity and to deal with this pain then I need tools, I need to have contact with people with whom I can share this pain, and contact with the patient, then the same bond that is what causes me the weight, is the bond that gives me relief from this pain, then the bond that hurts me and weighs me down in the face of suffering is the same bond that feeds my [own] healing. (Excerpt from the interview with MJ3, our emphasis)

When experiencing the bond, and in order to experience it in all its intensity, doctors have the chance to leave behind the labels of omnipotent, inaccessible, infallible, allowing themselves to experience this encounter without prejudice and/or defined expectations. In this movement, both physicians and users pass through the caring dimension of the encounter, in a space where both allow themselves to be heard and to be heard, to be cared for and to be taken care of. The bond itself stimulates the reconstruction of a new existential territory with more potentiality, which goes far beyond a discursive repetition fragile, imposed, and unquestioned. Such potential comes from the encounter thus



experienced, and leads to a deactivation of that identity territory that once seemed solid, armored, immutable. In this way, the light technologies, already decisive in the process of deterritorialization that are effective, now begin to be operated with even greater ease, and the caring encounter materializes in a territory filled with new possibilities of configurations of care for oneself and the other.

## Final considerations

The origins of medical identity territory go back to the origins of humanity itself, possessing elements that give body to the idea of power and infallibility of the doctor. In several ways doctors can experience a deconstruction of their self-referenced existential territory, perceiving themselves as impotent, fallible, imperfect. The result of this may be callousness, as if in an attempt to avoid the discontinuation of their place of omnipotence, re-territorializing themselves in a reinforcement of the identity of “being doctors”. Or, when another deterritorialization happens, it can lead to feelings of suffering and anguish, and illness.

On the other hand, in the context of the intercessor encounter, doctors experience, in the acts of health care, the possibility of bonding with their users, and from the symmetrical bonds may provoke re-territorializations in which doctors assume their ignorance and discards the idea of omnipotence to tread a new ground with their patients: a caring encounter.

Even as watertight as socially accepted medical identity might appear to be, medical identity territory can be partially deactivated and diverted in other re-territorializations in a dynamic and constant manner. Whether it is for disarming oneself from a posture of infallibility, for recognizing the potency and knowledge of the other (user, team), or for allowing oneself to be affected by the feelings of the other and recognizing that there is potency to act in this encounter, doctors can then make use of their experiences in the reconstruction of their professional identity.

Above all, bonds will play a central role in the re-territorializations, as doctors incorporate as a new value the potency of the caring encounter for themselves and the others. As tectonic plates in movement, medical identity territories may then assume a dynamic character, producing deviations and new configurations of “doing medicine”, in a constant transformation in which light technologies can be intensely operated in the framework of the caring encounter.



### Authors' contributions

All authors have actively participated in all stages of manuscript preparation.

### Conflict of interest

The authors have no conflict of interest to declare.

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Estudo qualitativo com abordagem cartográfica que teve como objetivo compreender os efeitos que o vínculo e a responsabilização entre médicos de família e usuários produzem nos próprios médicos. Foram realizadas dez entrevistas abertas por meio de perguntas disparadoras com médicos de família e médicos residentes. A análise das entrevistas se deu sob o referencial da micropolítica e problematizou, com base nas experiências relatadas, a existência de um “território identitário médico”, bem como as possibilidades de desconstituição desse território, sua desterritorialização no sentido de novas reterritorializações, a exemplo de afastar-se da onipotência/infalibilidade não para sofrer, mas para cuidar de si e do outro. Propõe-se que, nesse movimento de reconstrução do território identitário, tanto médico como usuário passem a transitar pela dimensão cuidadora do encontro, em que tecnologias leves podem ser operadas e novas possibilidades de configurações do cuidado acontecem.

**Palavras-chave:** Medicina de família e comunidade. Longitudinalidade do cuidado. Vínculo. Cuidado centrado no paciente.

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Estudio cualitativo con abordaje cartográfico cuyo objetivo fue comprender los efectos que el vínculo y la toma de responsabilidad entre médicos de familia y usuarios producen en los propios médicos. Se realizaron diez entrevistas abiertas a partir de preguntas desencadenadoras con médicos de familia y médicos residentes. El análisis de las entrevistas se realizó con base en el referencial de la micropolítica y problematizó, a partir de las experiencias relatadas, la existencia de un “territorio de identidad médico”, así como las posibilidades de desconstitución de este territorio, su desterritorialización en el sentido de nuevas reterritorializaciones, con el ejemplo de apartarse de la omnipotencia/infalibilidad no para sufrir, sino para cuidar de sí mismo y del otro. Se propone que, en ese movimiento de reconstrucción del territorio de identidad, tanto el médico como el usuario pasan a transitar por la dimensión cuidadora del encuentro, en donde tecnologías leves pueden operar y suceden nuevas posibilidades de configuraciones del cuidado.

**Palabras clave:** Medicina de familia y comunidad. Longitudinalidad del cuidado. Vínculo. Cuidado centrado en el paciente.