

Sociology of the Medical-Patient Relationship: Putting Flesh on the Bones of a Stick Figure

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Abstract

Any activity, including science, and the doctor-patient relationship, depends on society. The institution of medicine is based on social relationships that are defined exclusively by experts, and this involves cultural definitions, values and techniques. The institutions define the right practices independently of the people involved. Social practices are full of conventions, uses, rituals, styles, modes, procedures, laws, etc. Institutional power defines the individual doctor-patient relationship. This scenario places limits on the positivist view of the patient-centered relationship. Social institutions make their social agents-doctors-first interested in outputs, products or results (cures, prescriptions, visits, demand, hospital admissions, diagnoses, morbidity, mortality), but not in social relationships, which they are frequently hidden or distorted. In this way, the doctor-patient relationship is frequently trivialized and treated in a child-like manner as a professional matter: it is presented in the biomedical literature as a stick figure; a "prehistoric" oversimplification that is little like the current reality. The sociological approach brings doctor-patient relationship to the surface, making it visible, demystifying and problematizing it. The general practitioner should: 1. Go from medicalizing social relations, including the doctor-patient relationship, to socially contextualize medical practice and the doctor-patient relationship; And 2. Take charge of social problems from the consultation, understanding that social problems are part of the consultation and the doctor-patient relationship.

Keywords: general practice; framework; physician-patient relations; sanitary attention; physician-patient communication; social influence; social power; sociology, medical

Introduction

"A stick figure is a very simple drawing of a person or animal, composed of a few lines, curves, and dots. In a stick figure, the head is represented by a circle, the arms, legs and torso are usually represented by straight lines. Details such as hands, feet and a neck may be absent, and the simple stick figures".

By doctor-patient relationship we understand the set of conditions and types of social behaviors that concur in the action between the doctor and the patient, as well as the doctor's relationship with the object of his activity. From the medical point of view, the doctor-patient relationship has a determining importance, due to its therapeutic value. That is, the transcendence of the doctor-patient relationship is given by the confirmed fact of its influence on the results of health care (1).

Doctor-patient relationship has been and remains a keystone of care. But, there are many ways of understanding, classifying and practicing it. So, doctor-patient relationship is a complex, multiple and heterogeneous concept. Doctor-patient relationship is conformed by several aspects, among which we can point out the doctor-patient communication, the patient's participation in decision-making and the patient's satisfaction. These characteristics have been associated with the physician's communication behavior and the patient's autonomy in medical care (2).

When we try to investigate human relationships or interactions determined by well-defined expectations and attitudes shaped by culture and the environment, we find ourselves, in fact, facing a purely sociological problem. In addition, the doctor-patient relationship has been subject, in the course of social development, to changes. Therefore, to understand this doctor-patient relationship we need the sociological view (3).

The cognitive identity of medical sociology has developed in a historical perspective in the context of a specific double frame of reference including medicine and general sociology. However, general medicine (GM) and sociology are two disciplines that have different paths, and that in recent times may seem divergent. On the one hand, the GM sought greater medical respectability in a greater biomedical approach, while its underlying biopsychosocial model was increasingly marginalized and weakened. On the other hand, many sociologists rejected medicine and the epidemiological study of health problems and increasingly restricted their interest in social theory and qualitative research (4,10).

The social study of health began as medical sociology and then morphed into sociology of health and illness, focusing largely on the social aspects of health-related topics. Social scientists have been reluctant to tackle disease in its physiological and biological manifestations. The result is an impoverishment of sociological analysis on at least three levels: social scientists have rarely made diseases central to their inquiries; they have been reluctant to include clinical endpoints in their analysis; and they have largely bracketed the normative purpose of health interventions. Consequently, social scientists tend

to ignore what often matters most to patients and health care providers, and the social processes social that scientists describe remain clinically unanchored. A sociology of disease explores the dialectic between social life and disease; aiming to examine whether and how social life matters for morbidity and mortality and vice versa (11). Therefore, there is an interdisciplinary gap between GM and sociology, which is detrimental to the investigation of the social aspects of health.

In any case, it could be said that the task of sociology is modest but vital. His field is the study of human society. Sociology is an essential aid for making intelligent judgments about the direction of society in a changing world. Any activity, including science, and the doctor-patient relationship, depends on society. Sociology studies human society and selects its own specific scientific methods to explore the special nature of human society, which is not fixed and permanent, but fluid, elusive and changing (12).

By applying sociological tools we can examine the so-called objective factors in the determination of health and disease, the socially constructed nature of these categories of knowledge, and the struggles and power relations that determine whether or not such categories are viable (10, 13). With the growing scope of scientific and technological discourse within medicine, social scientists need new theoretical tools to deal with the complex links between medicine, science and society (14). Culture depends on individuals for their continuous readjustment and modification, and even more for social relations. The increasing role of general practitioners (GPs) has been accompanied by a greater concern for those aspects directed toward an understanding of human behaviour (15).

The understanding of the doctor-patient relationship has been explained historically through different interpretative schemes linked to the historical moment and the social context. The reality of the doctor-patient relationship has become a highly complex relationship that is situated in a network of relationships characterized by increasing contingencies and changes in each of the components. They change the needs of users and their cultural definition of health and illness, increase their expectations and demands regarding the doctor, but lose confidence in themselves; they change the professional models of the doctor, the relationship becomes more impersonal, hurried and superficial, each time more "objective" technical instruments are used and subjectivities are avoided. In short communication becomes increasingly unlikely (16, 17).

In GM, with each patient that is attended in the consultation, we do not find an isolated man, but an "emissary" of the context or society. The GP knows that it must try to understand that the individual, as such, is not only the main actor of a drama that seeks clarification through analysis, but also the spokesperson of a situation carried out by the members of a social group (his family, institutions, etc.) (18).

Therefore, there are two ways to contemplate the disease:

1. The individual clinical course which is linked to the medical theory of the disease (objective, biomedical) and hides the contextual, cultural and social and subjective dimensions of it. It revolves around professionals. It is the dominant discourse in medicine.

2. Another way of looking at the disease is not from its individual course but from its collective or social experience (interactionism or intersubjectivity, situational analysis). It revolves around situations of power, institutional frameworks, socio-economic and media influences, experiences of self-help, mutual help or self-care, empowerment, etc. It is a hidden discourse in biomedical literature (12, 19).

In this scenario, the doctor-patient relationship is frequently

trivialized and treated in a child-like manner as a professional matter (including its more "democratic" formulation of patient-centered medicine). This article aims to draw attention to this situation, which leads to generate a huge amount of medical literature on the subject, which in reality is empty of social content, which usually makes it ineffective in real life. Therefore, this brief text, intends to rethink about the real doctor-patient relationship, so that it can be reformulated and addressed in an adult and useful way.

Discussion

The sociological approach of the consultation

This type of consultation approach is interested in understanding the behavior not between a doctor and a patient, but between "doctors" and "patients", and tries to identify social roles that influence and predict behavior in the consultation. These factors or social roles are defined as significant elements of behavior and carry the beliefs shared by the members of a group (in this case, doctors and patients). It is thought that there are 2 significant social factors that govern social action: values and norms. Values refer to beliefs shared at an abstract level, and norms are concrete ways of feeling, thinking and acting, which are reflections of a set of beliefs.

Social values can influence behavior in the consultation due to:

A. Groups such as doctors, patients and social classes may have different beliefs and behavioral norms
 B. Both doctors and patients will behave according to the rules of their respective roles

Social factors influence many diseases and can be fundamentally responsible for the patient's decision to seek medical help. Social factors can also affect the outcome of the consultation as they influence the way in which the success of the consultation is judged.

When biomedical knowledge and technology create the capacity for humans to avoid disease and circumvent early death, sociological factors become more, not less important for population health. The transformation of disease causation from cruel fate, accident, and bad luck to circumstances that are under some degree of human control facilitates a powerful social shaping of disease and death. When humans have control, it is their policies, their knowledge, and their behaviors that shape the consequences of biomedical accomplishments, and thereby extant patterns of disease and death (20). Consequently, a "social configuration approach" is needed that can frame our understanding of these processes.

The Institutions condition the relationships between people

In the course of the history of humanity, in addition to the advance of science and technology, the most important change that has taken place between culture and society is the development of money and the economy, which applies to all spheres of life, including medicine.

In the contemporary world the spheres of life in which institutions are embedded become monopolized fields by specialized practitioners on whom we all depend; like doctors (and lawyers, bankers, teachers, etc.). The specialists share a vision of the world.

The growth of institutions in the relationships of people provides one of the most important tasks of sociology. The different institutions (economy, law, medicine, education, etc.) are based on social relations that are defined exclusively by the experts. Institutions involve cultural definitions of social relationships and incorporate values and techniques in their practices. The institutions define the right practices independently of the people involved. The social practices are full of conventions, uses, rituals, styles, ways, procedures, laws, etc., that define and condition the institutions (12). However, organizations have become a neglected issue within medical sociology and health policy analysis (21).

Thus, the doctor-patient relationship is not an entirely informal, purely intimate encounter, fundamentally determined by personal qualities, but it presents certain general structural elements, is integrated in the system of social relations and norms, is based on expectations, regulations and reciprocal demands of participants' behavior, establishes certain norms of conduct for both parties, and corresponds to the sociological concept of an institution (22).

The way of relating among people is based on patterns of behavior defined, learned, accepted and shared by a cultural construction. These relationships can be affected by a negative assessment, exercised on certain characteristics of those who assume other people's guidelines or different from those established by society as standards; consequently, behaviors of discrimination and rejection that impede interpersonal interaction will be obtained.

The doctor-patient relationship, as a specific type of interpersonal relationship, is susceptible to experiencing this type of behavior, since it reflects the same criteria and ideologies of the society to which it belongs (12).

The priority for the result or the product

Social institutions make their social agents are first interested in outputs and outcomes (cures, prescriptions, visits, demand, costs, hospital admissions, diagnoses, morbidity, mortality ...), but not in social relationships. Due to the priority in the "result" or the "product", the social relations involved in the maintenance of the institution are often hidden from view. The sociological approach brings them to the surface, making them visible, and demystifying or problematizing to them (12).

While clinical guidelines are designed to help physicians in their account of the changing state of the art and of the evidence-based medicine, the situation of these medical guidelines seems to be critical as it leads to a biologizing objectification of medicine, which means to avoid social decisions. Along with this, there is a tendency to mystify the medical role. This trend supports the authoritarian direction of the doctor (23).

Thus, specific forms of therapy, such as those derived from the nature of the disease in question, and from formal organization, rather than from the personal characteristics of the participants, condition the specific relationships between doctor and patient.

Further, the doctor-patient relationship is not an entirely informal, purely intimate encounter, fundamentally determined by personal qualities, but it presents certain general structural elements, is integrated into the system of social relations and norms, is based on expectations, regulations and reciprocal demands of the participants' behavior, establishes certain norms of conduct for both parties, and corresponds to the sociological concept of an institution (22).

Sociology of the doctor-patient relationship

In each field of sociology the practices of an area of society and the social relations that give rise are connected. This concerns the origin of the doctor, with his social status, his professional ideology, his general power over patients, and his relationships with science and with other professionals. Sociology shows that a profession or occupation, like medicine, takes a certain direction depending on social forces, technical knowledge, its values and the demand for its services.

The history of science is not a simple matter of truth or falsity, but its theories and methods have been discarded and developed for different reasons. For example, the announcement of a medical discovery is an event that reflects professional rivalries and commercial pressures as

well as the communication of a new truth. The theory of the paradigm suggests that it is preferable to approach a whole set of practices sociologically, including their methods of research, organization, economics, training, etc., than to consider each one of them in a isolated way. For example, when approaching the figure of the doctor, it is preferable to do it on the whole of their networks of relationships, shared ideas, etc. (12)

The interrelation of biology, society and culture produces classical sociological controversies, such as those referring to sex and gender, social class, etc. Gender divides occupations; women demand more care in relation to raising, caring for children, etc. That higher health demand in women reflects "the work of women." Likewise, the middle social classes face institutions better than the lower classes. Etc. From the sociological point of view, the human body, as a place of health and disease, is hidden by the requirements of power. Thus, you can not explain a disease only from medicine. For example, hepatitis or Alzheimer's can not be explained as explained by biologic medicine, without taking into account sociological factors. It is easy to think, that this scenario influences the understanding and conceptualization of the doctor-patient relationship (12)

The doctor-patient relationship, insofar as it involves two people, carries the imprint of the social context in which it develops. This situation demands that the doctor assume, with full clarity and precision, several factors: in principle, the structure of their values, then the awareness of the way in which their personal judgments define a person, based on the principle of identification, and, in addition, the way in which both values and judgments influence the decisions about acting in professional practice; these aspects prevent him, consequently, seeing things from the perspective of the patient. Sociological research has shown that doctors and patients can have different perspectives from an interview, and that doctors give meaning to their experiences from their role in their institution, and patients give meaning to their clinical experiences in the context of their lives and beliefs (24, 25).

Social conditions and socially created individual competencies are important facts that determine the experience of chronic diseases and doctor-patient relationships.

Thus, for example, regarding the important clinical task of giving reassuring news to the patient, the methods usually used such as emphasizing the mild nature or the early diagnosis of the disease, do not necessarily lead to a reassuring interpretation by patients. As said before, patients give meaning to the doctor's words within the context of their experiences and their lives. And so, in theory, the physician's knowledge of the patient's vision of his health problem is an important element to be able to reassure him, but the doctor tries to achieve this knowledge from his professional and institutional role, which necessarily creates a disagreement between both visions (26, 27).

When the clinician approaches the sick body of his patient, he sets in motion cultural practices charged with meaning, socially created and incorporated into his way of being, the same ones that are projected during the medical act, establishing three types of judgments: social, scientific and subjective. In the first, the society based on its representations, establishes an abnormality that does not necessarily correspond to a disease. In the second, the disease that manifests itself in a patient is identified by the knowledge and skill of the doctor to diagnose, and through the indicated treatment obtain relief, cure or rehabilitation of the patient. In the third, the social judgment is confirmed by the doctor (member of the society) who perceives that something different from what is established as a norm occurs in the patient, so he classifies it as an individual different from the others. Therefore, their response in the treatment corresponds to discrimination and rejection (28).

Thus, for example, a positive test for antibodies against HIV or an AIDS diagnosis changes many aspects of a person's life, including the type of relationship he has with his doctor. The same can be applied to other diseases. On the other hand, it is necessary to take into account that medical treatments have little to do with the effective health of people, either because they do not eliminate the social causes of the diseases, or because by intervening diffusely on the population they create new pathologies (16). It is not taken into account that the biological is conformed by the social through the mediating link of the

psychic (22).

Health can not be reduced to taking drugs. To the extent that doctors accept this premise of health equal to drugs, gives the impression that the medical profession has lost almost all their self-esteem based on the doctor-patient relationship (12), and this biomedical approach, where everything is technology and drugs, completely modifies the doctor-patient relationship (29,31).

The language and the human relationship: Institutional power defines the individual doctor-patient relationship

The exchange and production of ideas in human interaction takes place through language. Two theorists of the twentieth century, the German Habermas and the French Foucault, maintain the main points of view on this subject. Habermas believes that one can only completely and freely construct communication when each person has the same possibility of expression in the relationship. Foucault defends that the tensions of discourse are always established through power; and thus it is not a pair of interlocutors, but rather it is a process of social construction in which innumerable participants take part. This points to the main point of sociological analysis: power defines the situation, and this relationship is not in the hands of a person, or of the interlocutors-doctor and patient. In order to understand the meaning and structure of clinical experience and of the doctor-patient relationship, it must be framed in the history of the institutions in which its organizational effort has been manifested (12, 32).

Historically it can be said that long before the end of the eighteenth century, there was already the concept of "clinic" and the doctor-patient relationship. In the dawn of humanity, before every system, medicine, in its entirety, resided in an immediate relationship of suffering with what alleviates it; it was established by the individual by himself and for himself, before entering a social network. But, since the eighteenth century, what defines the act of medical knowledge in its concrete form, is not the meeting and relationship of the doctor with the patient, nor the comparison of a medical knowledge with a perception of the patient; but it is the systematic crossing of two series of information homogeneous one and the other, but alien to each other; two series of information that develop an infinite set of separate events, but in whose cut or isolable act, gives rise to the individual event (32).

Currently, in this doctor-patient relationship, there is a scenario of growing demand increasingly trivial from the point of view of the doctor, and a lack of understanding by the patient of what constitutes a good scientific and technical quality. This is interpreted by the doctor as an inappropriate communication. On the other hand, in front of this social behavior of the patient, a cognitive and behavioral defense of the doctor emerge (17).

Verbal communication is a crucial part of the doctor-patient relationship. The language is determined by the person speaking. To speak is to share power. Individual actors are spokespersons for power rather than individuals who make independent moral judgments. This puts limits to the positivist view of the doctor-patient relationship, even in its version of patient-centered (12).

Specific forms of therapy, such as those derived from the nature of the disease in question, and from the formal organization, rather than from the personal characteristics of the participants, condition the specific relationships between doctor and patient. Thus, the doctor-patient relationship is not an entirely informal meeting, purely intimate, fundamentally determined by personal qualities, as usually preached from the biomedical literature, but it presents certain general

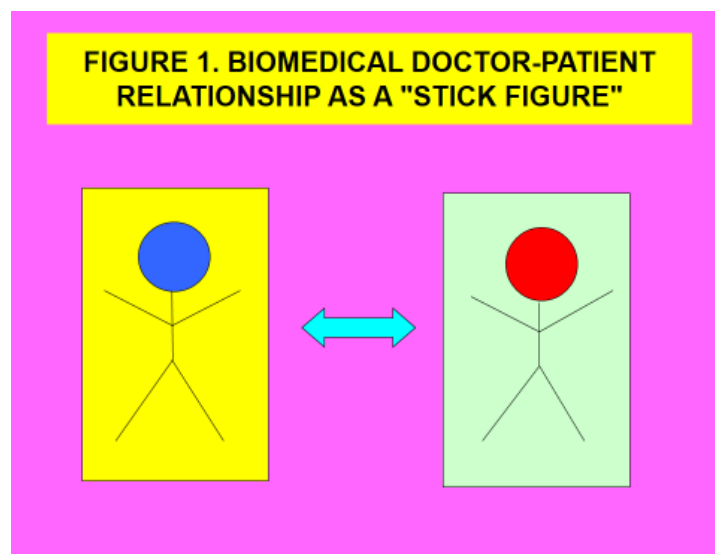
structural elements, is integrated into the system of relationships and norms social, is based on expectations, regulations and reciprocal demands of the participants' behavior, establishes certain rules of conduct for both parties, and corresponds to the sociological concept of an institution (22).

Interpersonal behaviors can activate feelings of power. People with a high tendency to seek power are more likely to give advice than those with a low tendency. The delivery of advice is a subtle route to a feeling of power, shows that the desire to feel powerful motivates to give advice and highlights the dynamic interaction between power and advice (33).

Finally, it is necessary to keep in mind that the concept of patient empowerment, which is a key issue in public health, medical sociology and public debates on the modernization of medical care, also has social bases. The patient's empowerment behavior in the doctor-patient relationship has repercussions in this relationship. A spectrum of four behaviors of the patients that govern the practice of empowerment have been described: delegate, inform, consume and resist. The findings suggest disturbing changes in the role of the doctor-patient relationship in including these behaviors. In this way, it is found that some patients assume responsibility for their health, employing tactics in which the role of GPs is severely degraded and as a consequence the therapeutic potential of the doctor-patient relationship is modified (34).

Conclusion

It can be concluded that the usual analyzes of the doctor-patient relationship are "a stick figure". The origins of the "figure of the stick" are in prehistoric art, later in writing systems that use images for words or morphemes, such as Egyptian and Chinese; it is then a simplification of something much more complex. The evidence on the doctor-patient relationship presented in the vast majority of biomedical studies represents, at best, "stick figure", a "prehistoric" simplification that must be completed by sociology.



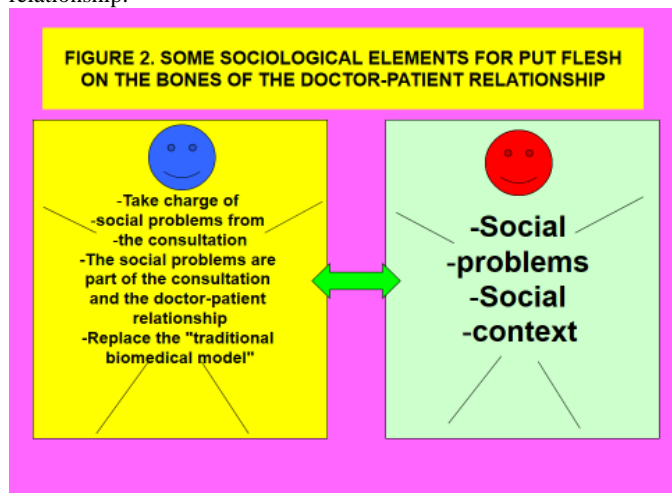
(Figure 1). Biomedical Doctor-Patient Relationship as a "Stick Figure"

This biomedical view of the doctor-patient relationship does not show social conflicts, power relations, or emotional elements.

It must be remembered that "disease", "illness", "sickness" can not be separated from the practice of GM: pathology, experience and social repercussion of the health problem. With the growing scope of scientific and technological discourse within medicine, GPs need new theoretical tools to deal with the complex links between medicine, science and society. Sociology of the disease and the doctor-patient relationship should explore the dialectic

between social life and disease. Although it is clear that there are some researches that synthesize the conceptual perceptions of the doctor-patient relationship and the sociology of medicine, at present this is quite limited. A new sociology of the production and application of medical knowledge, especially regarding the doctor-patient relationship, would represent an important way forward.

The GP must take into account the evidence provided by sociology, so that he can fill in the gaps in the stick figure of biomedical evidences, and "putting flesh on the bones" of doctor-patient relationship.



(Figure 2). Some Sociological Elements for Put Flesh on the Bones of the Doctor-Patient Relationship

The GP should go from medicalizing social relations, including the doctor-patient relationship, to socially contextualize medical practice and the doctor-patient relationship. What defines the GP's role is to take charge of social problems from the consultation. It is not a matter of GPs, from the GM consultation, having to solve social problems, or that social problems can be or should be taken into account (which is too vague a concept), but that social problems are part of the consultation and the doctor-patient relationship.

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