

Clinical Medicine, Public Health and subjectivity:

conversations with David Armstrong



Sergio Resende Carvalho^(a)

This text is intended to synthesize in the form of an 'interview' several conversations that I had with Prof. Armstrong during my stay in London in the year 2014/2015 as a Visitor Scholar at King's College of London^(b).

As a professor of Collective Health, I tried, after an extensive review of Armstrong's theoretical writings, to explore some issues that seem of particular interest to academic debates and interventions in the Unified Health System in Brazil. Medicine – as an invention and as one important mechanism of knowledge and practice that fabricate the body/person - the role of clinics, healthcare, risk and Public Health are some of the themes that we reflect here.

It seems to us that in his research Armstrong advances one of the central goals of Foucault when the philosopher sought to create a story of the different ways by which, in our culture, the human being is produced (and is manufactured) as a subject. Reflecting on his genealogical studies the role of discourse in the constitution of the subject, the discontinuity and disruption of thought and the significant role of chance and contingency in the production of 'real', Armstrong follows a tradition that aims to, more than understand the present by examining the past, to disturb our self-evident present: a kind of research that indicates for us the instability that is inherent in our present and invites us to make it possible to imagine and to invent 'another world'¹.

Aware of the complexity of the issues addressed here we also suggest to the reader, those texts (see references) that allow a more in-depth appreciation of the themes that are discussed.

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^(a) Departamento de Saúde Coletiva, Faculdade de Ciências Médicas, Universidade Estadual de Campinas. Rua Tessália Vieira de Camargo, 126, Cidade Universitária Zeferino Vaz. Campinas, SP, Brasil. 13083-887. sresende@fcm.unicamp.br

David Armstrong

David Armstrong is professor of Primary Care & Public Health Sciences Department at King's College London. He is the author of the classic "Political anatomy of the body: medical knowledge in Britain in the twentieth century (1983)" and countless articles, chapters and books covering different themes of the health field^(c).

In those texts, the author describes and discusses changes in the diagrams of power/truth and subjectivity production throughout the twentieth century, reflecting on their effects on the nature of the body/individual, on knowledge and practices (medical, nursing, professional psy, etc). Deserving mention, among others, is the emergence of an important new medical model - Surveillance Medicine - which influences and challenges other formulations - hospital medicine/pathology and others – and the directions of clinical practice in the United Kingdom.

^(c) See: <https://kcl.academia.edu/DavidArmstrong>

Political Anatomy of the Body

What do you mean by 'Political Anatomy of the Body' which is the title and the subject of the important book (2) that you published in 1983?

I took the title from Foucault's 'Discipline and Punish: the Birth of the Prison'³ where he refers to a new political anatomy (of the body) that was forged through 'a new machinery of power that explores it, breaks it down and rearranges it'. I presume that he adapted the term from 'Political Economy': he noted that 'the two processes – the accumulation of men and the accumulation of capital – cannot be separated'.

Can you comment on a central claim in your book² that the body which emerged at the end of the eighteenth century - discrete, objective, passive, analyzable - was, as Foucault argued, the effect as well as the object of medical inquiry?

Yes, my book on political anatomy was a footnote to Discipline and Punish³. But whereas Foucault had concentrated on the late 18th century, I wanted to see the extent to which these 'mechanisms of power' had changed in the 20th century and what effects these had had on the nature of the body/individual.

What do you mean by the argument that what the student of medicine sees is not the atlas as a representation of the body but the body as a representation of the atlas?

I placed this argument early in my book as I wanted to challenge the assumption that the body is somehow 'real' and the anatomical atlas only a description of that reality; but it is only through the atlas that we can see the body (in the form it describes). In the same way, I am unable to see the 'meridians' of the acupuncturist but if I had their equivalent atlas I expect these would then become visible to me.

Do you agree that this radical notion of a fabricated body and subject by mechanisms of power inevitably confronts and challenges traditional medical sociology which takes the human body as a point of departure for a bio-psycho-social science of health and illness? Can you comment it by discussing the difference between what you call a weak and a strong programme of social constructivism in sociology⁴? Can you exemplify it comparing the liberal and Marxist perspective with the Foucaultian one?

I agree that medical sociology assumes that body exists as a biological object and progressive politics insists on taking a biopsychosocial view of illness. I have worked, however, from a different assumption. In many ways the fundamental problem is biology (a science that is barely 200 years old); as Foucault noted in *Birth of the Clinic*, pathological medicine, which is the biological view of the human body and disease, is neither the first nor the last way of construing illness.

There was a debate in the sociology of science many years ago that distinguished between a weak and strong programme. The latter involves being completely agnostic about the truth of any science claims, whereas the former would only accept that sometimes scientific truth can be distorted but at other times is a good reflection of 'reality'. I would apply the same sort of distinction in social constructivism. There are some sociologists who argue that some diseases, such as mental illnesses, are socially constructed, whereas other biological diseases, such as cancer or heart disease are somehow more real. My position is that all diseases are constructed but that those diseases, particularly those rendered as 'biological', that hide their constructed nature are in many ways the more interesting to explore as the way this concealment occurs is intriguing.

The liberal progressive movement in medical sociology is to promote a more humanist medicine but within a framework of biological constraints. As indicated above, I have problems with this perspective. Marxist analysis also makes assumptions about man's nature (after all, he can be alienated from himself) and, despite some Marxist commentators who focus on ideology, I have yet to come across one who would take the position that biology is part of the superstructure. My reading of Foucault is that he would support my position were he alive!

How would you analyze the projects that try to expand the biomedical model to include, as Engel argued, the psychosocial to build up a biopsychosocial model of health and illness⁵?

The biopsychosocial model of medicine can be analyzed in three ways. First, it is a more humanist and progressive way of dealing with patients; second, it represents a subtle attempt by a powerful medical profession to extend its jurisdiction into not only the biological domain but also the psychosocial; or, third, it represents another mechanism of disciplinary power through which patients (and doctors) are constituted with biopsychosocial identities.

As you reflect on 'The disappearance of the sick man from medical cosmology'⁶, many of us in Brazil work with the idea that 'the advent of the hospital and the dominant role of doctors' and the 'emergence of a medicine based on pathological lesions'⁷, underpins the process of alienation and objectification of the patient. This comprehension has spurred a rich production that seeks to liberate and empower the patients.

What do you think about this theoretical and political project if we think, like you do, that following Foucault, 'there was no ordinary individuality, the autonomy, the discrete body, prior to the advent of the hospital and its clinical techniques (and the associated procedures found in prisons, schools, workshops, and barracks'⁴?

I can find no evidence for this mythical, liberated, un-alienated and non-objectified patient before the emergence of pathological medicine in the late 18th century. The reason is simple: such a patient did not exist; in fact this patient was actually constructed rather than suppressed by this new approach to illness. But of course if it is believed we have a humanist identity this cannot be 'invented', almost by definition, so a mythical past is created in which we were free. A similar argument applies to the Marxist concept of alienation which needs a Golden Age sometime in the past when Man was not alienated.

I have no problem with a programme that seeks to liberate and empower patients, I only seek to undermine its theoretical justification and point out, following Foucault, that we can never be free of power.

Surveillance Medicine

At the summary of your article 'Surveillance Medicine' of 1995⁸ you claim that:

Despite the obvious triumph of a medical theory and practice grounded in the hospital, a new medicine based on the surveillance of normal populations can be identified as emerging in the twentieth century. This new Surveillance Medicine involves a fundamental remapping of the spaces of illness. This includes the problematization of normality, the redrawing of the relationship between symptom, sign and illness, and the localization of illness outside the corporal space of the body. It is argued that this new medicine has important implications for the constitution of identity in the late twentieth century. (p. 393)

I would like to discuss some aspects of your research findings. First, can you describe what you mean by the remapping of the space and time of illness and the changing meanings of normality and illness^{2,8}?

As Foucault described in his *Birth of the Clinic*¹¹, during the late 18th and early 19th centuries doctors started to examine the physical body of the patient so they could identify pathological lesions inside that corporal space. But in the 20th century that medical gaze has turned to examine spaces outside of and surrounding the physical body of the patient. These include the psychological and social spaces in which patients' worlds exist. I also noted that these new spaces seem to have a temporal dimension, as there was a new emphasis on the timeline of disease (such as in chronic illness or in screening for disease). The investigation of these new spaces of illness meant that there were no longer 'ill patients' who had a pathological lesion but patients who were at constant risk of illness: what was normal in regard illness was therefore changed.

What are the implications of the new 'Surveillance Medicine'¹² to the constitution of identity and the body?

In Surveillance Medicine it is no longer only the body that is examined but the whole life (lifestyle) of the patient who is constantly at risk from both seen and unseen dangers. Just as surveillance of bodies in the panopticon established the anatomical body of the prisoner, so the surveillance of everyone (in an attempt to manage risk) produces a reflexive identity, as the only response is constant vigilance.

Can you comment for us on the invention of new medical problems and of new medical specializations by the Surveillance Medicine model?

Surveillance Medicine produces a whole range of new medical problems, which have as their common characteristic the very need for that surveillance. Prime examples would be the way that the neuroses (anxiety and depression) replaced insanity as the main mental health problem and the invention of chronic illness during the 20th century; both of these 'inventions' then justified further surveillance.

In your discussion of the dispensary^{2,8} - 'the old Community Health Centre'(?), you maintain that it is "on the one hand, an extension of the panoptic vision to a whole society; on the other hand, its principle difference was its denial of the rituals of separation and exclusion that had characterized the exercise of panoptic power". Can you explain this idea for us and discuss if it applies to the UK NHS today?

The Dispensary was one of the earliest examples I could find of healthcare provision looking outward rather than inward. The hospital, as a panoptic structure, had admitted, examined and treated those people (patients) who had a pathological lesion. During the early 20th century this panoptic vision started to look outwards, into what we would now call the community. So whereas the hospital had separated and excluded ill patients, the new community focused health services did not differentiate between healthy and ill but offered services to all; in effect panoptic power became distributed throughout society. A core manifestation of that outward gaze today is the spread of comprehensive healthcare, which is largely to do with monitoring risk and the surveillance of the whole population.

In your writings you relates the 'invention' of the neurosis to the development of the Surveillance Medicine and, also, with the General Practitioners' (GP) practice^{2,12}. Can you comment on this and the way that GPs have been dealing with neuroses in their clinical practice?

In the 19th century only a very small proportion of patients were diagnosed as being insane and incarcerated in an asylum. In the 20th century, as the medical/panoptic gaze has extended into the community, new mental illnesses have been revealed that affect everyone in some way. So the neuroses of anxiety and depression are components of everyone's changing mood but it is only when they become 'clinical' – a very blurred line – that they become medical problems. Nevertheless, monitoring the population to identify the extent to which these aspects of 'normal' mental functioning are becoming 'clinical' is an important part of healthcare provision today. I am reminded of the mental health surveys in the second half of the 20th century that consistently found most of the population at any one time had some form of mental illness.

We, in Brazil, have been working hard to build up a comprehensive and universal health care. You seems, in your work, critical of this common sense view that would claim those goals as representing a progressive and libertarian approach when you explore, on your writings, the disciplinary function of this kind of health care.

I don't believe that I have been critical of comprehensive and universal healthcare which, as you point out, reflect a progressive and liberal approach. I simply want to point out that there is another way of reading the spread of these services that does not owe its justification to progress.

I'm not sympathetic towards the argument - that seems to me that reflects a juridical - Marxist view of power - that sees it as negating, repressing and controlling (as you indicate above). But I am concerned, like Foucault, with how power is a creative force. So, yes there is a lot of monitoring and control in modern society and in modern healthcare but if we study power 'where it becomes capillary, where it has its immediate effects' I think you will find that the reaction of patients to these systems and technologies is not passive. Indeed, it is the response to this surveillance apparatus that is the most interesting in terms of its ability to fashion new patient identities.

Medical Models

After Ackerknecht you propose a classification of medical models as 'Library', 'Bedside', 'Hospital-pathological' and then added Surveillance Medicine^{7,8}. Can you explain what are the essential characters of those distinct models and, after, describe for us how those models makes up the identity of individuals?

I found this classification of medical models useful as the hospital-pathological period is where Foucault's analysis of the Birth of the Clinic (and of panoptic power) comes in. If we accept that the hospital period reflects a reconfiguration of the nature of power – from sovereign to disciplinary – then I think we can identify yet another medical model in Surveillance Medicine that applies panoptic power across the population. And just as the disciplinary power of the panopticon established anatomical bodies (in schools, workshops, prisons and hospitals), as Foucault observed, I think that the more pervasive surveillance machinery, of the late 20th century, reconstructs individuality and gives it both a sense of agency and reflexivity.

Taking as a reference point your discussion of time and space, about the meaning of illness and the normal, in the above models do you think that the analysis that Nikolas Rose has presented recently in texts such as 'Politics of life itself'¹³ point out to an emerging new medical model?

I think that Rose and I are writing parallel accounts of similar phenomena although we each seem to have a different focus. I have mainly been interested in the 'rise and fall' of the biological; in contrast Rose is interested in the role of biology today, particularly molecular biology. And whereas I prefer to write brief accounts of certain forms of conceptual emergence through the study of journals and textbooks Rose is much better at describing the sweep of the big picture.

Patient's autonomy

In several of your texts, especially in 'Actors, patients and agency'^{12,14,15} you have said that over the recent decades several strategies have been developed to encourage patients to have greater autonomy in life and that the result has been to induce a sense of agency in previously passive patients and to a reconstruction of the patient's identity. This issue is of great interest to the various projects in the interior of Brazilian Collective Health and National Health System that seek to rethink clinical and management approaches so as to achieve comprehensive care, quality and equitable health for all. After those comments, can you summarize for us the main aspects of this historical development?

As I described in my paper I think the key shift occurred in the 1950s when the idea that everyone was susceptible/at risk to unseen and unknown dangers became prevalent. This can be seen in the idea that everyone is at risk of disease, in the unseen dangers of pollution to our environment and in the contemporary McCarthyite concerns about the spread of communism (the red under the bed syndrome). I particularly like the film Invasion of the Body Snatchers of 1956 in which aliens take over human bodies: on the one hand dangers are everywhere and unseen and at the same time, for those taken over, identity is transformed.

Social critics of medicalization usually relate this phenomenon to a lessening of patient autonomy. How should we view these critiques in the context of your argument that medicine today seeks, in many occasions, to reinforce the autonomy of the patient⁴?

I think that recent analyses of medicalization have stressed the shift from active doctors to active patients. It is less doctors who want to transform the problems of everyday life into diseases and more patients and patients groups who wish to medicalize their problems whether it is fatigue or obesity or whatever.

How do those developments reflect, today, on the medical-patient relationship in general practice in the UK? Did it have impact on clinical practice, in the way that health professionals deal with disease and its symptoms?

Yes, both the doctor-patient relationship and clinical practice today are very different and reflect these changes. Doctors must now respect the autonomy of the patient, involving them in decisions and giving them responsibility (sometimes whether they want it or not). And on the other hand much of clinical practice today is engaged with identifying and mitigating risk factors rather than what would have been called pathological diseases.

Can you illustrate the transformations that have occurred in terms of the problem of adherence of the patients¹⁴ to medical treatments and Public Health programmes (such as TBC, cancer prevention, etc)?

The problem of adherence is a relatively recent one. Before about 50 years ago there was a little mention in journals and books about defaulters from treatment (mainly from venereal disease clinics) but otherwise nothing about patients complying with medical advice. So why is it that adherence/compliance emerged as a problem that medicine had to address 50 years ago? This is not a problem of biology but of behaviour and it is about 50 years ago that doctors became increasingly concerned about identifying, studying, managing, classifying and changing behaviour. Adherence provides the perfect problem for this project.

In a similar way, public health programmes have a nominal target – such as the prevention of cancer – but they are concerned with much more important strategies. For example, cancer screening recognizes and thereby promotes a temporal dimension for disease, the wide prevalence of cancer risks in the normal population, the importance of promoting uptake of the service (that is targeting behaviour) and, more recently, informed choice (which targets mental/cognitive functioning as well as behaviour). So, in summary, I think it is interesting to take all of these apparently 'obvious' medical policies and enquire why and when it became possible for them to emerge as 'obvious' even though a few decades earlier they could not even be imagined.

Public Health

In your research you describe the changing configuration of the boundaries between medicalized spaces in terms of four models of public health spaces¹⁵. Can you comment on these models and, in your answer, discuss their changing conceptualizations of risks to health?

I thought that the four regimes of Public Health I identified, Quarantine, Sanitary Science, Interpersonal Hygiene and the New Public Health, could be arranged according to their focus on the human body and the degree of permeability of the body boundary. For each of these Public Health regimes there is associated risk (though this term has only been applied to the most recent): in each case it is the dangers associated with crossing the boundary. In Quarantine, for example, crossing the boundary could potentially be catastrophic and was totally forbidden; but as the Public Health models succeeded each other new strategies had to be devised to guard/monitor an increasingly permeable boundary. We are now in a situation where risk cannot be averted by sanitary hygiene but requires vigilance against unseen dangers everywhere, all the time.

How can you relate those different concepts of risk (and the different Public Health models) with the production of an individual identity?

The strategies deployed to manage the dangers in different Public Health models serve to constitute the nature of contemporary identity, whether it is an anatomical body under Sanitary Science or a reflexive identity under the New Public Health.

When you maintain that in the late twentieth century the individual has become a risk from his or herself, what are the consequences of this development for clinical practice¹⁵? Do you think that it is possible to affirm, like Ogden¹⁶ that the mutation of the risk conception parallels changing concepts of identity over the last century?

In my recent paper on the history of agency in medicine (and medical sociology) I pointed to the importance of the idea that everyone is susceptible to unseen and unknown risks. With this realization everyone must be constantly vigilant. This provides a powerful analytic framework. On the one hand, risks of any form can be added to the threats we all face whether it is addiction, sexual disease, obesity, environmental pollutants, etc. On the other hand, the proliferation of these risks everywhere requires the individual to become more and more vigilant against internal and external threats. And I think this process leads to a sense of agency and reflexivity that characterizes identity/patients in the early 21st century.

United Kingdom's National Health System

What can you tell us about Primary Health Care in the UK, nowadays? Which medical model has the greatest influence?

Primary health care (a new term coined in the 1960s for the old general practice) today embodies many features of the 20th century transformations I have tried to describe such as an increasingly autonomous patient who expresses agency, an emphasis on risk profiling and a much more population/community focus.

What characterizes, in your opinion, the GP's relationship with patients (and the family and community)? What is the main focus of the clinical setting: the potentially pathological symptom or, regardless of the meaning of the symptom, to seek psychological access to the intimacy of the patient and, from there, to what it influences?

The changing nature of the doctor-patient relationship is an important facet of contemporary general practice but I would also point out the importance of risk profiling whereby patients who attend have their risk factors measured and calibrated (and even those who do not attend can themselves be analyzed for the risk factors that produced non-attendance).

In 'Surveillance Medicine' symptom, sign, investigation and disease becomes conflated into an infinite chain of risks. Equally, the illness in the form of the disease or lesion that had been the endpoint of clinical inference under Hospital Medicine, is also deciphered as a risk factor in as much as one illness becomes a risk factor for another. Beside commenting on this claim can you illustrate with an example and reflect on the consequences of this new gaze in clinical practice?

An example: a person eats junk food; this increases the risk that their lipid profile will be altered; this increases the risk that they will develop angina; this increases the risk that they will have a myocardial infarction; this increases the risk that they will die; this increases the risk that their child might carry a cardiovascular gene; this increases the risk that the child, especially if they eat junk food, follow a similar trajectory. Last century medicine would not have been interested in this chain of risks, but now it is. Moreover, we know with increasing accuracy the level of probability of each of these transformations and although the overall risk remains very small, it is the fact that we are all aware that we are at risk that is important for both the patient and clinical practice.

You claim in 'Political Anatomy of the body'² that in 'Surveillance Medicine' the reasons for 'visiting the doctor' and the whole configuration of illness, patient, and doctor was ... rearranged. And, from it emerged... the gaze to the subjective patient since it was the patient's meanings, decisions and subjective world which triggered the decision to consult rather than the dictates of a localised, organic pathology', that - as Balint would argue - diagnosis must be like biography and is inseparable from treatment'. Taking this claim as a reference point can you discuss and analyze the influence of those aspects on the 'International Classification of Primary Care' proposal and about its applicability nowadays in the UK and in other countries' primary health services?

Any classification system can be unpacked to reveal the values and assumptions that made it possible. The International Classification of Disease (which has its origins over a century ago) tells us that diseases are things that are mainly located inside the (biological) body and describable in terms of cells, tissues and organs. It was only in the last half-century however that primary care has attempted to develop a parallel classification. At first, it used an adapted ICD but gradually it has come to incorporate aspects of the patient's behaviour and motivation. It seems to me that this shift can be read as placing a new focus on the cognitive and behavioural aspects of patients' identity – which is the mechanism through which these attributes are constituted.

Surveillance Medicine has, as we have discussed, a great influence on the practice of General Practitioners, Pediatricians and Gynecology/Obstetricians. In this sense how do you explain that the UK has prioritized the GP as the specialization of Primary Health Care and didn't incorporate specialists such as (general) Pediatricians and ('general') Gynecology/Obstetricians in its system? I am asking you it because in Brazil this keeps being an important discussion in the Public Health field.

The place of the GP in the British National Health Service is really a historical accident. During the 19th century the high status specialists (physicians and surgeons) worked in the hospitals and restricted their 'general' practice to patients who could afford their high fees. This left the GP to manage the healthcare needs of everyone else. Towards the end of the 19th century a number of local insurance schemes emerged in which members of a community each paid a weekly small amount so that a GP could be employed to provide healthcare whenever anyone was ill; this was the beginning of capitation in which the GP is paid for the number of patients they have registered and not for individual services. The National Health Service, introduced in 1948, simply extended the GP's role and capitation system of payment to the whole population and restricted the specialists to the hospital. Capitation in effect rewards the GP when his or her registered population is healthy and brings about work when they're not (whereas fee-for-service has the opposite incentives). Further, the government has ensured that GP and specialist salaries are roughly equivalent.

Many researchers have been writing about the links between strategies underpinned by the concept of risk in Public Health and conservative political proposals^{1,17,18}. Ogden, in a text that engages with your conception of risk¹⁶ alerts us, for example, that in " the last decades of the twentieth century, the surveillance machinery, which finds reflection in the individualistic and self-reliance ethic of the New Right, has successfully penetrated the spaces of the body to reconstruct an intra-active identity which is increasingly compartmentalized into the controlling self and the risky self". What do you think about those ideas?

I have never been persuaded that an analysis of the surveillance machinery is helped by seeing it in terms of political movements such as the New Right. If anything I would imagine that the New Right is another manifestation of surveillance/risk/agency rather than the other way round. And of course, while surveillance produces an individualistic and self-reliance ethic that the New Right might applaud, the ongoing surveillance of everyone – as recent news has demonstrated – is, ironically, opposed by the New Right.

To finish this conversation. Can you comment on the 'methodological' approach that you have used in the works that we have discussed here? Why do you think that it points to 'another way of reading some reality or some discursive text'?

In the last chapter of my most recent book - *A New History of Identity*¹⁹ - I tried to describe some of the methodological principles I try to use in my research. I think that two are very important.

The first is the significance of the text rather than the author. This has been an important theme across post-modern studies over the last couple of decades and I tried to make it inform my own work. The conventional view is that the author creates the text but it is more interesting, I think, to say that the text creates the author. If we want to know who Freud really was we must infer from his texts; and as that inference will change over time so the identity of Freud will change according to how we interpret his texts. So I have been unconcerned about who has written a specific text – indeed I would prefer it if the text came from a reasonably obscure source so that no one would be tempted to look for the author's identity, background, motives, etc. In the sense that I am trying to explain the author I need to reverse the usual relationship of authors to text. Therefore, I often try to keep the author's name out of the things I write but, of course, conventional referencing requires me to provide a name somewhere.

The second methodological principle is to order texts according to their year of publication. Most libraries order books by author or subject but never by date. For example, in a history of medicine library there will be a section on 19th century medicine with books published over the last two centuries. This seems very strange as the nature of 19th century medicine can only be known from a certain temporal vantage point so why juxtapose a 19th 'primary' text with a 'secondary' one from the late 20th century? My own book collection is therefore ordered by date of publication. This allows me to see similarities and dissimilarities in adjoining texts. I have tried to follow this precept in my writing though at times it proves difficult.

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