
Original Article

The invention of patient-centred medicine

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Abstract This article, based on a plenary presentation to the 13th biennial conference of the European Society for Health and Medical Sociology, challenges the implicit theme of the meeting, that radically changing societies have significant impacts on health and well-being. This analysis, it is argued, masks the fact that it is the ways in which we construe health and well-being that makes a major contribution to what we understand by 'radically changing societies'.

Social Theory & Health (2011) 9, 410–418. doi:10.1057/sth.2011.13;
published online 5 October 2011

Keywords: Patient-centred medicine; society; identity

The title of the 13th biennial conference of the European Society for Health and Medical Sociology was 'Health and well-being in radically changing societies'. This title was framed in the programme and publicity material as how societies – in radically changing forms – have impacted on health and well-being. This article, however, based on a plenary presentation at the meeting, asks to what extent this question is a valid one and whether there can be other readings of the relationship between society, health and well-being. In particular, the article questions whether society and health/well-being are separate constructs and what might be lost by considering them as causally related.¹

Risk and Medicine

In his classic text, *Birth of the Clinic: An Archaeology of Medical Perception*, Foucault (1973) identified a period in the late eighteenth century when a new medicine emerged that localised illness to a pathological lesion inside the human body. This new framework for understanding illness also helped to redefine the nature of health as simply the absence of disease/pathology in that those without



pathology could not be construed as ill. In the mid-twentieth century, however, the pathological model of disease has been challenged by a new form of clinical practice that has stressed the centrality of risk factors and medical surveillance for understanding health and illness (Armstrong, 1995). In this new form of medicine the relationship between the symptom (what the patient reported), the sign (what indications of underlying pathology the doctor could elicit in the clinical examination), and investigations (to confirm the provisional or differential diagnosis), which together had pointed towards the precise pathology underlying the illness, become reformulated as 'risk factors'. In fact pathology itself, the old locus of disease, becomes a risk factor because it too pointed towards future health-related events. For example, whereas several decades ago hypertension was a disease, nowadays it is a risk factor for stroke. Stroke, in its turn, could be construed as a risk factor for dying, which is a risk factor for those genetically related to the dead person, and so on. In similar fashion, other former diagnostic labels, such as diabetes, are rapidly being redefined as risk factors.

The identification of risk factors began to dissolve the distinction between the normal and the abnormal (or the physiological and the pathological in medical parlance) as the illness state becomes more blurred. In this new world of medicine, everyone is potentially ill and no one is truly healthy as everyone has a particular risk factor profile that can be managed by a vigilant medicine. This new configuration of health and illness might explain the extension of health care from its narrow focus on the hospital out into the community and into everyday life during the last half century – an aspect of the clinical practice that has of course received critical recognition by sociologists in their identification of the dangers of medicalisation (Zola, 1972; Conrad and Schneider, 1980; Conrad, 2007).

The other significant feature of Surveillance Medicine is that risk factors are not only derived from the previous intra-corporal predictors of disease, but also from numerous factors that exist outside and around the human body. Environmental factors, stress, behaviour, lifestyle and so on, mainly belonging to the psychological and social domains, have become legitimate targets for health-related actions. The fact that health inequalities have become a major evaluative criterion of much health care delivery attests to the power of this new explanatory model.

Risk factors therefore exist both inside and outside the human body and one risk factor elides into another. This means that health is no longer a dichotomous variable, that everyone is at risk and that calculating and recalculating risk profiles becomes part of the core task of medicine. In this context the impact of radically changing societies on health might be construed in terms of how those societies have affected or transformed the distribution of these risk factors; and yet, the very idea of a health care system focused on risk factors



(rather than pathological lesions) – and indeed the management of risk more generally – has become an integral part of how societies have become radically different over recent decades.

A New Public Health

The history of public health is often presented as a story of constantly improving population health. Yet such a progressive history masks a number of distinct periods of public health practice that seem to underpin certain forms of human identity (Armstrong, 1993). Before the mid-nineteenth century the only generalised public health strategy was that of quarantine that maintained a strict ‘cordon sanitaire’ between two geographical spaces such as ships, towns and countries. The cordon sanitaire marked a complete prohibition on communication between two spaces and applied equally to inanimate objects, animals and people.

In the mid-nineteenth century, a new model of public health emerged in the form of sanitary science. Like quarantine, sanitary science was also concerned with maintaining boundaries, but in this case the lines were not between relatively anonymous geographical spaces but followed the anatomical contours of the space of the human body. This boundary line, however, could not be a line of total exclusion as in a cordon sanitaire: it had to allow the passage of food, water and air into the body and ensure the proper disposal of anything leaving the body. This led to what has been called the Golden Age of public health in which water supplies and food hygiene were significantly improved – as was the attention to the quality of air though the application of miasmatic theory has subsequently fallen into disuse. Equally new sanitary measures ensured that those substances leaving the body such as urine, faeces, sweat, phlegm, and so on, were removed, diluted and decontaminated, a process exemplified by the widespread construction of sewers in the second half of the nineteenth century. In retrospect, most of these nineteenth-century changes were of considerable benefit to the health of the population, yet what is of interest here are the similarities and differences between quarantine and sanitary science as spatial strategies. Both involved drawing lines of exclusion around areas – geographic in the case of quarantine, anatomical in the case of sanitary science – but in one it was a line of total exclusion whereas in the other it had to be a permeable boundary.

The process by which the perimeter of the human body was demarcated from nature by the application of hygienic rules was further reconfigured at the beginning of the twentieth century with the advent of interpersonal hygiene. This new regime of public health was called social medicine in continental Europe and preventive medicine in the United States, but the British term of interpersonal



hygiene perhaps best captures its essential features. In this public health regime a space emerged between individual bodies that became a focus for new clinical and political practices. The space between bodies was physical in nature, a gap across which danger could pass. Tuberculosis, for example, had been a disease of dirt and insanitary conditions in the nineteenth century, but became one of interpersonal contact as campaigns against spitting and coughing were instituted. Equally, interpersonal hygiene reconstructed the nature of venereal disease as one of human interaction rather than simple immorality as new clinics were established and contact tracing introduced. The new space between bodies identified and characterised by interpersonal hygiene, however, was not only a physical space but also a psycho-social one in which the new sciences of psychology and sociology could find their application. Indeed, early twentieth century ideas that infant and childhood relationships have a formative influence on later identity belong to this new regime of interpersonal spaces.

In the mid-twentieth century yet a new source of health dangers materialised and these were addressed by what has been called the new public health. The latter involved a further redrawing of boundaries. In particular, the hazard of dirt that allowed nature to penetrate the envelope of the human body under sanitary science was reversed as nature became a beneficent force. The problem now was pollution that came primarily from a magnified and multiplied interpersonal space. It was the interaction of many bodies, such as in industrial production, which was seen to be the source of greatest hazards, such as 'mad cow disease', collapse of the protective ozone layer and dangers of food additives. It was therefore no longer the single other who was potentially dangerous, but the collectivity of others.

Within a period of roughly 100 years public health transformed itself three times. From maintaining a permeable boundary around the discrete human body, through guarding against passage of danger across interpersonal space, through protecting individual integrity against the polluting effects of others, public health changed its targets and its practices. And each regime of public health both addressed and in a sense created new objects, the anatomical body in the nineteenth century, psycho-social spaces in the early twentieth century, and a form of reflexivity in the new public health. The need to guard against pollution elicited a 'green' response and a need for constant vigilance against dangers that were largely unseen and that could rarely be contained by formal boundary maintenance strategies. An individual who was constantly vigilant against dangers everywhere was someone who became reflexive, considering not only the hazards that permeated everyday life, but also of their own 'risky self' (Ogden, 1995).

No doubt radically changing societies have contributed to the pollution that is the target of the new public health, and in this respect the impact of societies



on health and well-being is clear. Yet there is another side to this question: recognition of the dangers of this new form of pollution is itself a part of radically changing societies that reconstructs both the nature of the 'natural' environment and identity itself.

Measurement

The changes in public health during the second half of the twentieth century described above accord well with the emergence of risk factors in clinical medicine, but these changes can also be identified in other aspects of medicine. For example, the measurement of health status under pathological medicine had largely been based on the absence of pathology or at least the deviance of biological norms. But in the 1970s a new construct emerged, quality of life (alongside the idea of 'lifestyle') (Armstrong and Caldwell, 2004), and during the 1980s this was operationalised through a series of related concepts such as subjective health status, health-related quality of life and, latterly, patient reported outcome measures and well-being all of which attempt to capture the subjective state of the patient (Armstrong *et al*, 2007).

Similarly, until the mid-twentieth century the classification of disease was largely based on ordering the pathological causes of death. The International Classification of Diseases (ICD), which embodied this pathological medicine perspective, was extended in the 1950s to capture non-fatal diseases, but by the 1970s was recognised to be deficient as it struggled to contain the new aspects of patienthood that were then emerging. Between 1978 and 1987, a series of initiatives in classification development produced the International Classification of Primary Care (ICPC) that gave central place to the 'reason for the encounter', that is why the patient had chosen to consult with health care services. This represented a radical change from the past: whereas the older classification had been based on the disease/pathology, or its cause, the new classification was founded on trying to capture an aspect of patient behaviour (Armstrong, 2011). The idea of illness, therefore, for so long associated with the presence and direct causes of the pathological lesion began to be transformed – at least in primary care – as the idiosyncratic patient together with the reasons and rationale they provided for their actions moved towards the centre of the clinical mission.

So again the question can be asked: what was the effect of radically changing societies on health-related quality of life and well-being of patients, and how can these outcomes be measured at the population level according to different and changing ICD and ICPC categories? But the alternative question is whether these measures and classifications are themselves part of the society from



which they emerged. In effect the very criteria of medical/health care success have been redrawn over the last few decades.

Subjectivity and Death

Nineteenth century psychiatry had been entirely concerned with madness or irrationality in all its different forms. By the post-war years, however, the main focus had shifted to the neuroses that involved identifying how patients coped with their emotions (Armstrong, 1980). Moreover, reflecting the shift from discrete pathology towards generalised risk factors, it was observed that these neuroses, in the form of anxiety and depression, were ubiquitous throughout society and individual biographies; and if the neuroses were everywhere then this further justified the surveillance of everyday functioning of the population. The role of the mental functioning of 'everyone' is also to be found in the emergence in the 1980s of a concern, particularly by social scientists, with the experience of illness. Before this discovery patients *had* illnesses; after they began to *experience* illness. Similarly, the history of medicine-taking has moved from pre-war concerns with defaulting, through compliance to the more patient-centred notion of adherence. More recently the idea of concordance, in which doctor and patients strive to agree on medication decisions, has gained wider recognition.

These various developments in the 'subjectification' of the patient are mirrored in shifts in ideas behind the clinical encounter. Balint *et al* (1970) differentiated illness-centred from person-centred medicine. A few years later, Byrne and Long (1976) revised this dichotomy into doctor-centred versus patient-centred, and Engel (1977) produced his biopsychosocial model of medicine. All these changes reflected a crystallisation of patient subjectivity and reflexivity that had not existed in previous years. Of course it is still possible to ask whether radically changing societies have influenced the emergence of patient subjectivity and reflexivity (and the degree to which medical sociology has promoted the patient's voice) but there remains another question, namely the degree to which the very notions of subjectivity and reflexivity are part of the reasons why societies are believed to be changing.

A further example of these recent changes is the conceptualisation and management of death (Armstrong, 1987). Before pathological medicine, in the early eighteenth century and earlier, death came from outside life often as a black-cloaked figure, scythe in hand, ready to knock on the door of life and take it away. But then, with the advent of pathological medicine, a new form of pathological death emerged in which death did not come from outside the body and life, but rather grew as an internal structure (in the form of a pathological lesion) within the body. This in its turn meant that the practice of pathological



medicine was based around the clinical examination of the patient's body so as to identify the exact nature of the underlying lesion, while the temple of truth was the post-mortem dissection in which the actual cause of death could be identified and then recorded, from the mid-nineteenth century, on the new death certificate. Foucault summarised this new configuration in the way of seeing death as the apex of a triangle of life, death and illness: 'it is not because he falls ill that man dies: fundamentally it is because he may die that man may fall ill' (Foucault, 1973, p. 155).

In 1961, however, a new form of death emerged in the western world that might be called normal death. For thousands of years, the chief mourners at a death had been the friends and relatives of the dead person, but now, in a great reversal, patients were encouraged to express anticipatory grief as they mourned their own death and provided confession to the health professionals providing care. This change is reflected in the advice given in nursing texts before and after the appearance of normal death (Armstrong, 1983a, b). When pathological death still dominated, the advice to nurses was not to talk to the dying patient about death as they might find this distressing. A few years later, under the new regime of anticipatory grief, the injunction was to listen and explore feelings and views about death as this was the only humane thing to do.

As ideas about normal death and anticipatory grief began to inform clinical practice, the pathological lesion that for over 100 years had dominated the truth about death began to be relegated to an uncertain status. A number of studies in the 1960s began to cast doubt on the validity of post-mortem findings. The cause of death identified from a post-mortem was reported to be unreliable, and indeed the fact that 'we all die from cardiac arrest' anyway made the exact trigger for death difficult to identify (in consequence there has been a marked decline in post-mortems over the last few decades). In summary, before about 1830, there was natural death that came from outside of the body, between 1830 and 1961 there was pathological death that came from inside the body, and since 1961 there has been normal death that comes from inside the patient's mind. Such a reconfiguration of death seems less to be the consequence of a changing society and more a significant manifestation of it.

Health Behaviours

The involvement of the patient's subjectivity and reflexivity in the practice of medicine is also reflected in changes in models of causation. Whereas, pathological medicine used largely biological explanations for the emergence of its pathologies, the new medicine, particularly in its emphasis on risk and subjective factors, has begun to fix with even more tenacity on human



behaviour, which is now held to be the basis of much illness and distress. A study of the *Lancet* and *American Journal of Public Health* (Armstrong, 2009) showed that the use of the word behaviour in the nineteenth century was very infrequent and only applied to inanimate objects such as blood and epidemics. In the early twentieth century, behaviour began to be applied to people's actions but essentially in terms of a biologically driven, non-voluntaristic movement of the human body. It was only in the 1950s that behaviour began to be construed as the product of 'a deliberate taking of thought'. Indeed, the migration of a number of scientists to the problem of behaviour in the 1950s, from Kinsey in sexual behaviour through the ethologists in animal behaviour to ideas about Type A behaviour in heart disease risk is evidence of the growing attraction of behaviour as an explanatory concept in this period. In many ways, the centrality of behaviour to health care, despite its recent 'discovery' surely reflects more on the very nature of modern society than its effects.

Summary

The core question of the ESHMS congress was how radically changing societies had affected health and well-being. But there is another way of posing and answering this question that does not see it simply in terms of cause and effect, of a society bringing about changes in health and well-being. Instead, at the core of a 'radically changing society' there seems to be a major process of social transformation that affects how we perceive and act towards health, its nature, its measurement, its determinants, its effects and so on. In many ways, the changes that began half a century ago – and are still being played out – represent a major shift in clinical practice and the way health is construed. Revolutions are seldom recognised until they are over or near their end and it is perhaps now time to recognise that the events that began between about 1950 and 1980 changed not only how we think about health and illness, but also the society we live in.

About the Author

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Note

1 This article draws on a number of my published papers as well as two monographs (Armstrong, 1983b, 2002).



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