Patient agency and system-level procedural priming toward medical interventions: Tensions of a responsible self in GDM healthcare contexts of risk mitigation

Abstract

Stretched to the limits of resources and capacity, the public healthcare system of the National Health Service (NHS) in the UK has increasingly foregrounded patient responsibility in managing their health conditions. This implicates what may be understood as patient agency, e.g., "the patient's capacity to engage efficiently with, act on, and assume responsibility of their state of health" (Armoundas and Loscalzo 2025: 1; my italics). By such definition, patient agency can be seen as instrumentally mobilised in service of a service delivery in which it is itself deeply entangled.

While patient agency may be desirable to enhance a sense of self-efficacy, potentially improving health outcomes, it may at the same time present a double-edged sword, whereby responsibility can become responsibilisation. This can be experienced by the patient as blame for perceived failures in self-management of their health condition by means of prescribed behavioural adjustments, as to diet and exercise, couched within parameters of measurable targets. One such example is the monitoring of in-range blood sugar readings in the case of gestational diabetes mellitus (GDM), a condition of elevated glucose levels that can arise in pregnancy.

Such self-management forms part of indirect control within a system constrained not only by resources and capacity but by risk management, itself underpinned by both a medical ethos of care as well as the institutionalised avoidance of clinical, legal, and reputational consequences of adverse happenings. Both may be encapsulated in the vision and charted pathways towards 'favourable outcomes', which are conceptually founded on a shared responsibility of risk between patient and healthcare professionals.

In the case of GDM, the vision is towards 'favourable birth outcomes', while the avoidance is of birth complications. Although patients are typically expected to self-manage at diagnosis of GDM, charted pathways of care and risk mitigation include medical and birth interventions often introduced from the outset of care. Here, I argue that this early management of expectations represents a form of system-level procedural priming evident in guidance to healthcare professionals given by the National Institute for Health and Care Excellence (NICE) in the UK, which contrasts with other countries as well as supranational guidance. I argue that a better understanding of patient agency and its structural destabilisation should take a system-level priming of projected pathways and epistemic probabilism in communication between patient and healthcare professionals into account.

In order to do so, agency can be both temporally situated and understood in relation to multilingual and multicultural experiences within the system itself as well as across

systems, such as those of other countries and supranational conceptualisations of illness and care. I revisit the sociological work of Emirbayer and Mische (1998) in order to retheorise patient agency within the temporal and culturally relative situatedness of system-level procedural priming. Conceptually, I build on my prior work (Nao 2025) on framing of epistemic authority and the difficulty of navigating and resisting institutionally stabilised interpretations.

References

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