

Autonomy-Supportive Medical Education: Let the Force Be *Within* You!

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As teachers, we often struggle to get “inside the heads” of our learners. Given that we have much to teach and they have much to learn, how can we best motivate them to acquire new knowledge and skills, and then to integrate these knowledge and skills sets into practice? Perhaps we have this question backwards. The science of motivation teaches that we should not try to motivate learners so much as find ways to stimulate their own innate desire to learn and grow.^{1,2} Understanding human motivation may do more to improve medical education than a briefcase full of curriculum models, teaching techniques, and assessment tools.

The application of one extensively studied and validated theory of human motivation, self-determination theory (SDT),¹ could help both learners and teachers develop their full personal potential.² SDT focuses on the fulfillment of humans’ basic psychological needs for *autonomy*, *competence*, and *relatedness*.¹ It teaches that individuals who pursue goals through intrinsic motivation are higher achievers than those who are extrinsically motivated by rewards and punishments. Learners achieve more when they can act with volition and with minimal external controls that challenge their autonomy. SDT does not promote freedom from rules, but a combination of intrinsic motivation and autonomous self-regulation.¹ For example, the student who acts professionally because he or she has developed a sound professional identity with integrated, internalized rules of conduct contrasts with a person who is subject to external regulation alone, and who complies with rules to avoid punishment, but only while enforcement persists. Autonomy-supportive education

gives learners choices, acknowledges their perspectives, encourages their acceptance of personal responsibility, provides them with constructive feedback, evaluates them using individualized assessment, and grants them full responsibility for specific tasks once they have demonstrated mastery.²

Looking at medical education from the perspective of SDT is instructive because clinical settings bristle with extrinsic controlling forces—from economic and legal constraints to physician rating systems—that regiment the work of faculty and residents alike. Directives from accrediting bodies reinforce these controls through rigid schedules juxtaposed with mandated work hours and pervasive systems that track and evaluate performance. How can we foster autonomy in students, residents, and faculty in the face of these controlling forces?

Our department is currently engaged in a project to develop an autonomy-supportive climate and curriculum for residents.³ Our goal is to help residents exercise their autonomy in the learning process and become self-determined, self-regulating learners. We also seek to help faculty renew their personal commitment to acting as strong physician role models and becoming ever more conscious of the ways in which they may unwittingly undermine residents’ autonomy.

In a recent survey of residents and faculty about resident autonomy at our institution, we discovered a powerful interaction between autonomy and competence in the way faculty direct the clinical activities of residents. Faculty report that they provide more *autonomy* support by granting more independence to residents who both show assertiveness and demonstrate *competence*, while they give less latitude to residents who are passive and fail to think through a clear rationale for diagnosis or management. Residents, on the other hand, report frustration when faculty maintain tight control of patient care and perceive that faculty members grant them independence in making only insignificant decisions. A casualty of this tension is a healthy sense of *relatedness*

between faculty and residents who would all benefit from feeling that they belong to a professional community with shared aspirations and values.

Both adult learning theory⁴ and SDT posit that residents need opportunities to make decisions and learn from errors in a supportive and safe environment. Some of our faculty report that they set very clear expectations for residents in order to help them safely exercise more independence in decision making; however, most say that residents who are less competent and less autonomous have not “earned the right” (or created enough trust) to make decisions independently. We worry that these residents who most need support may be getting fewer chances to learn from the experience of clinical decision making. We are investigating the working hypothesis that residents with weak autonomy and competence may benefit if faculty learn ways to give them gradations of independence to scaffold their development.

Fortunately, most physicians-in-training start out with strong intrinsic motivation, and autonomy is easier to maintain than to build *de novo*. To create physicians who are not only well prepared for independent practice but also working to their fullest potential, we propose an educational system that maximizes opportunities for students, residents, and indeed faculty and staff to learn through a sound understanding of their own learning needs and strategies, exercised in the context of supportive guidance rather than extrinsic control. Those who guide the learners may also benefit from this educational model; when they support others in building autonomy through hands-on learning without compromising patient safety, we predict that both their teaching and trainees’ learning will be energized.

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