Clinical Review

Autonomy Versus Independence: Implications for Resident and Faculty Engagement, Performance, and Well-being

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Abstract

Description

Research shows that when educational leaders support their learners' autonomy, it positively impacts both parties. This is particularly important in graduate medical education (GME), given that there is a strong emphasis on resident performance, evaluation, and development. Unfortunately, GME faculty often misunderstand autonomy as the resident's desire for independence or "freedom," when in fact it refers to the core psychological need to feel volitional and agentic. The distinction is important because volition is not synonymous with independence, and providing freedom can be at odds with strategies that provide true autonomy support. This, in turn, can contribute to the stress, maladjustment, and resident burnout that are already prevalent in medicine. To help remedy this issue, this paper provides an evidence-based guide for medical educators to distinguish autonomy from independence, with specific examples to help translate theory into practice to better support the well-being of the medical community.

Keywords

autonomy; independence; psychological well-being; well-being; learning environment; residency training; graduate medical education

Introduction

Substantial evidence shows that support for human autonomy (experiencing volition and personal agency) promotes better engagement, performance, and well-being across domains such as business, education, and health care.[1] Conversely, using pressure, control, and external enticements, such as rewards to manipulate positive outcomes, often undermines the positive outcomes and well-being that organizations seek to foster.[1] According to Self-Determination Theory (SDT)[2]—a leading theory in human motivation, development, and well-being—this is because autonomy is a critical basic psychological need that, along with the basic needs for competence (feeling effective) and relatedness (feeling one belongs), is essential for human flourishing. In SDT, environments that support these 3 core needs con-

sistently outperform those that do not, while environments that actively thwart these needs see negative outcomes for both individuals and their organizations alike.

Various articles have discussed the importance of addressing controlling learning environments and adopting autonomy-supportive supervision in medical education to benefit medical learners and staff members.[3-11] However, a common implementation issue is that autonomy as a psychological experience tends to get misconstrued as *independence* or *freedom*. This likely occurs because in training contexts, the term autonomy is commonly used in medical education to describe independent decision-making by residents competent to do so. When medical education leaders (eg, program directors, department chairs, and faculty members) conflate the use of *autonomy* in this

context (independent decision-making) with autonomy as a psychological need (acting with volition or agency), it can undermine the critical psychological support for residents within the work and learning environment. Indeed, SDT holds that the optimal process to support the skill, growth, and confidence needed for independent practice is by providing support for autonomy in its psychological sense.

Autonomy as a Psychological Need

Autonomy is primarily concerned with *volition* (sense of purpose) and *personal agency* (sense of control) for one's actions, and is experienced whenever an activity is personally valued, interesting, or enjoyable. Since autonomous experiences can occur in both independent and dependent contexts, autonomy can manifest even when engaging in mandated activities or acting within a structured system that does not offer meaningful freedom. Indeed, in research studying the optimal conditions for autonomy in the classroom, autonomy was highest when teachers provided structure alongside additional support for interest-taking (ie, autonomy) in learning.[12]

In SDT, *autonomous motivation* refers to any motivation that reflects the interests, values, and endorsement of the self, whether those actions occur independently or within structured or dependent contexts.[1] Conversely, whether one is acting with independence or within structure, being motivated by contingencies and pressures thwarts autonomous functioning. Such motivation—whether based on external pressures (acting in response to incentives or punishments) or internal pressures (acting in response to negative feelings, such as guilt)—is considered to be non-self-determined and, therefore, *controlled motivation*.[1]

Understanding the concepts of "autonomous" and "controlled" motivation is important because both can manifest in similar behaviors and can occur in contexts of both independence and structure. Simply put, one might observe very motivated behavior on the part of 2 trainees, but the type or quality of the motivation beneath the surface can be vastly different. Importantly, research shows that this difference between controlled and autonomous

motivation results in meaningfully different engagement, performance, and well-being outcomes, with autonomous motivation significantly improving these outcomes.[1] This is why SDT focuses less on the intensity of motivation and more on its *quality* (ie, autonomous vs controlled), seeking to support autonomy in all circumstances and across all levels of independence.

Independence

Unlike autonomy, which is a basic psychological need that functions as an inner resource, independence refers to the level of "freedom" one is granted by the environment (ie, the absence of constraint in choice or action), often regulated by an individual or collective authority. For example, a driver first learns the rules of the road, then receives training with direct oversight and restrictions, before completing a supervised test to verify competence to be an independent driver. Similarly, physicians will practice and receive assessments on simulated procedures before they are supervised and assessed on performance of real procedures, and subsequently trusted to perform independently. These examples illustrate that individuals are often trained under tight controls and only granted independence based on a supervisor's assessment of readiness. Additionally, rules, regulations, and policies may exist that constrain the independence of both the supervisor and the individual under their care. This is particularly true in health care contexts, where patient care and safety dictate a high degree of structure and regulation. In short, there are many necessary constraints on independence in life generally, and in medical training in particular. Thus, if one understands the psychological need for autonomy to be synonymous with independence, one may incorrectly assume that there is little that can be done to support autonomous motivation.

The practical path out of this conundrum starts by understanding that autonomy is different from independence and that the perspective of authority figures is only half the story. The individual being governed (eg, resident) has their own reaction to whatever level of independence is being afforded to them, particularly with respect to their psychological experience of autonomy. Do they feel they have too

little independence and thus feel their personal agency is thwarted by overcontrol? Alternatively, do they feel overwhelmed by too much independence such that feelings of anxiety or uncertainty interfere with the interest-taking and volitional engagement that are necessary for autonomous motivation? From the perspective of SDT, autonomy can be supported or thwarted in circumstances of both high and low independence, and focusing on its fulfillment across both is the optimal path to maximize well-being and performance.

In residency training, autonomy support can indeed occur in circumstances of both high and low independence and begins with a consideration of the experience and expertise of the individual being supervised. Autonomy is best supported by high levels of independence when the resident has both the competence to carry out actions successfully, and the self-assurance that they can do so. Here the supervisor can, within the bounds of patient safety, adopt an approach that emphasizes giving the resident choice and discretion, focusing on being available for help and assistance in the resident's decision-making, as needed.

When competence is not yet developed, closer supervision and less freedom is often the optimal approach. Here too, autonomy can be supported by structuring more manageable challenges and providing closer guidance so that the resident experiences success and can grow in both their ability and confidence. Although such structure restricts independence, it facilitates autonomy by helping to manage stress, uncertainty, and anxiety about one's competence to perform, which creates more psychological space for interest-taking and volition. By providing clear rationales that link guidance and instruction to positive patient outcomes ("We are doing X because it benefits the patient in the following ways…"), faculty can help the resident endorse the guidance, internalize its value, and feel volitional about putting it into practice. This simple practice is one example of how instructors can support autonomy, regardless of the level of independence or freedom being afforded.

Similar strategies can also help support autonomy when independence is restricted more globally, such as by policies or regulations that impose non-negotiable constraints. Such circumstances can justifiably feel controlling and thwarting of autonomy (for both the resident and faculty), particularly when the purpose for the constraint does not make sense or is not well understood. In these situations of low independence, autonomy can again be supported by an increased focus on providing rationales and connecting the rules and constraints to their intended purpose.

Along with this, autonomy can be supported by taking a few moments to openly listen to the understandable frustrations that such regulations may evoke (whether imposed by faculty or by policy). This means accepting and acknowledging negative affect ("I understand how you feel. It certainly is frustrating.") without judgement. Such simple acceptance isn't just "being nice"; it serves an important psychological purpose by validating the resident's experience, thus allowing them to engage in tasks with more volition and personal agency (even when those tasks are constrained or unpleasant).

In sum, the optimal experiential goal is to provide support for high autonomy (volition and personal value) across all levels of independence, using 3 key strategies.[13]

1. Give a meaningful rationale. For people to internalize the value of an activity, they need a good rationale for why it ought to be done. Providing this relevance—and continuing to reinforce it—helps all residents to "buy in," integrate, and endorse the value as their own.
2. Address negative affect. Everyone benefits when faculty recognize that their standards and requests might not align exactly with what the resident wants or that global policies, regulations, or procedures may be frustrating and unpleasant to comply with. Alongside providing clear explanations and rationales, addressing negative affect (ie, points of resistance or frustrations) is an important additional support for resident autonomy.
3. Provide a sense of choice. Finally, autonomous motivation is optimized when the resident experiences some degree of choice. Individuals will be more autonomously motivated toward doing something

if they feel that they have some say over what they undertake or how they approach their work. While this is a more self-evident strategy for residents who have the competence to act independently, SDT research also demonstrates that giving smaller choices, wherever possible, can also facilitate autonomy satisfaction, even in circumstances where tasks are more structured, uninteresting, and/or mandatory.

A final point to consider is that the strategies discussed have also been shown to benefit medical educators directly. Teachers tend to become more autonomy-supportive once they realize how easy it is to do.[14] And being more autonomy-supportive to learners also benefits the teacher in terms of their sense of job satisfaction and engagement, passion for their work, and overall well-being.[15,16] Neufeld and colleagues have delineated a list of specific actions to support autonomy in medical education, showing benefits to both educators and trainees.[8,17]

Conclusion

While autonomy and independence are often seen as synonymous in residency training, these 2 concepts are, in fact, fundamentally different. Decoupling them gives medical educators an expanded toolkit to better support residents' autonomy and well-being, across circumstances of both high and low independence. Autonomy is a basic psychological need that is crucial for motivation and well-being. It is therefore important that it be always supported, regardless of a resident's level of competence and the independence that is afforded to them. Faculty members that work to support their residents' autonomy—through providing meaningful rationales, addressing negative affect, and offering a sense of choice—will notice multiple benefits for residents and themselves, including better work-related engagement and performance and, most importantly, well-being.

Conflicts of Interest

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