

WHEN I SAY

When I say autonomy

Adam Neufeld 

Department of Family Medicine, Cumming School of Medicine, University of Calgary, Calgary, Alberta, Canada

Correspondence

Adam Neufeld, Department of Family Medicine, Cumming School of Medicine, University of Calgary, Calgary, Alberta, Canada.

Email: adam.neufeld@ucalgary.ca**Funding information**

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1 | INTRODUCTION

Autonomy is a cornerstone of medical ethics.¹ Equally foundational are beneficence and non-maleficence. Yet, most scholarship in medical education still centres on learners—how trainees navigate supervision and identity—while giving little attention to how clinicians support autonomy in patients. When autonomy appears in curricula, it is usually framed narrowly: if patients get the final say, autonomy is presumed intact. This overlooks situations where patients feel overwhelmed or disconnected, even when choices are offered. In self-determination theory (SDT), autonomy is not the same as decision-making power—it is the experience of acting with volition, which clinicians can support or thwart. Without concrete guidance, learners may offer choices but still fail to create environments that truly support autonomy, sometimes even undermining it in ways that quietly, but meaningfully, cause psychological harm.

2 | A BRIEF HISTORICAL LENS

Decades ago, Williams and Deci found that medical students with autonomy-supportive supervisors reported greater motivation and delivered higher-quality care.² Later, they argued that modeling autonomy support was both educationally and ethically essential.³ These early SDT-informed papers showed that what learners experience affects patient outcomes but said little on how to teach clinicians to support patient autonomy. The result is a lingering conceptual muddle: autonomy is still confused with independence or reduced to informed consent.

3 | RELATIONAL AUTONOMY AND THE LINGERING GAP

Entwistle and colleagues highlighted relational autonomy, arguing that focusing on discrete ‘decision moments’ ignores the interpersonal conditions that make autonomy possible.⁴ Subsequent work has deepened our understanding of how training structures shape autonomy, yet a paradox endures: medicine’s core ethic is respect for patient autonomy, but learners receive little instruction on what autonomy is or how to support it. Bioethical principles remain abstract ideals rather than teachable, evidence-based skills.

4 | SDT: A ROBUST CLINICAL AND ETHICAL FRAMEWORK

SDT is one of the most empirically supported theories of human motivation, with over four decades of research spanning across disciplines.⁵ It identifies three universal psychological needs—autonomy, competence, and relatedness—which, when supported, foster engagement, well-being, and internalization, and when thwarted, contribute to stress, disengagement and harm. SDT also offers validated tools, such as the Healthcare Climate Questionnaire, enabling educators to move beyond rhetoric and assess climate and communication in meaningful ways. Autonomy, in this view, is not a standalone principle but a condition of volition—one nourished by support for competence and relatedness, without which it cannot fully flourish.⁶ The SDT literature has long recognized the role of autonomy support in health care and education, including comprehensive meta-analyses and theoretical reviews.^{7–9}

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5 | UNDERSTANDING SDT IN HEALTHCARE

SDT shows why *how* we communicate matters as much as *what* we recommend. When care aligns with patients' values, motivation becomes autonomous, and adherence improves. Autonomous motivation refers to actions patients endorse as personally meaningful, while controlled motivation involves feeling pressured—by guilt, fear or external demands—to comply. Evidence across diabetes, cardiac rehab, smoking cessation and mental health shows that autonomy-supportive care improves outcomes.¹⁰ These dynamics are especially important in marginalized groups, for whom emotional validation and involvement can be transformative.

6 | THE GAP IN MEDICAL EDUCATION

Despite its prominence in ethics codes, autonomy support remains under-taught. Learners master diagnostic frameworks but often lack the relational skills required to help patients feel capable, seen, and self-directed. Observational studies reveal a recurring pattern: clinicians present options but bypass the emotional scaffolding that makes those options meaningful.¹¹ Medical curricula miss a critical opportunity—to teach autonomy support not as an abstract principle but as a set of measurable, learnable behaviours grounded in motivation science.

7 | FOUR CLINICAL SCENARIOS: ILLUSTRATING AUTONOMY IN PRACTICE

7.1 | Scenario A: Supporting autonomy when options are limited

A patient with newly diagnosed type 2 diabetes is presented with an insulin regimen. He looks down and quietly asks, 'Do I have a choice?' The physician pauses. 'It might feel like there's only one path, but we can decide together what makes sense for your life.' She names the patient's fears—pain, cost, shame—and checks understanding: 'What questions do you have so far?' The patient admits confusion and fear of needles. Together, they co-create a plan aligned with his goal of walking his kids to school, starting with manageable steps. Here, autonomy is restored by linking treatment to personal values, while competence is supported by inviting questions and pacing information.

7.2 | Scenario B: Respecting dependence as an agentic choice

A frail older adult, overwhelmed by three complex vascular procedures, asks, 'Doctor, what would you pick?' Wanting to respect autonomy, the surgeon deflects: 'Only you can decide.' But refusing

guidance loads the decision onto someone who feels unable to judge—a subtle form of abandonment. Autonomy support means not equating choice with independence but honouring the patient's wish to lean on expertise. An autonomy-supportive response would share a recommendation, explain the reasoning and ask how it fits with the patient's values.

7.3 | Scenario C: When consent is not autonomy

A resident works through a goals-of-care form, describing each intervention neutrally but failing to ask how the patient feels. The patient, sensing there is a 'right' answer, nods along, anxious not to inconvenience anyone. Though the form is completed, the decision does not feel like his own. An open prompt—'What worries you as we talk about this?'—could have surfaced unspoken fear, validated emotion, and turned controlled acquiescence into self-endorsed choice. In this situation, autonomy support lies in emotional attunement—not checkbox completion.

7.4 | Scenario D: Identity and the erosion of autonomy

A transgender patient requests contraception to suppress monthly bleeding. The clinician agrees but avoids eye contact and refers to the patient by the wrong pronoun. Though the prescription is issued, the patient begins to doubt the interaction—not medically, but relationally. They leave feeling unseen and uncertain. Here, autonomy is not threatened by the absence of choice but by the absence of connection. A simple shift—using affirming language and checking in with curiosity—could have supported relatedness and restored agency.

8 | BRINGING SDT INTO MEDICAL EDUCATION

These scenarios show how even well-meaning clinicians can thwart autonomy and how small, intentional shifts can restore volition and trust. Translating these into teachable skills is a prerequisite for ethical, high-quality care. SDT principles can be embedded into existing communication training without expanding the curriculum. Because autonomy, competence and relatedness operate synergistically, teaching strategies should integrate all three.⁶ This includes value elicitation, emotional validation, teach-back and scaffolding patient confidence.

Faculty development workshops can address common myths, model autonomy-supportive communication and use validated tools for self-assessment. Evaluation methods like OSCEs and mini-CEX can assess empathic inquiry, rationale provision and adaptability to social context—not just factual delivery. These practical applications help move autonomy support from an abstract ideal to a demonstrable competency.

This paper offers a conceptual and practical reframing of autonomy through SDT but does not fully address contexts where autonomy support may be constrained, such as language barriers, systemic discrimination or time-limited encounters. Nor does it explore institutional and curricular levers for sustaining autonomy-supportive training longitudinally. Future scholarship should explore how to embed these practices equitably and sustainably across diverse clinical settings.

9 | CONCLUSION: WHEN I SAY AUTONOMY

When I say autonomy, I mean more than informed consent. I mean the felt experience of volition, supported by need-nurturing relationships. SDT demonstrates that autonomy support is not just an ethical imperative—it is clinical best practice. It transforms autonomy from a static doctrine into something actionable: a psychological need that can be supported, measured and taught. Embedding autonomy support in medical education will help realize medicine's promise: to heal without harm and to partner with patients in the fullest sense.

OTHER DISCLOSURES

None reported.

DISCLAIMERS

The views expressed in this article reflect the views of the individual author and not necessarily the position of affiliated institutions.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

ORCID

Adam Neufeld  <https://orcid.org/0000-0003-2848-8100>

REFERENCES

1. Beauchamp T, Childress J. Principles of biomedical ethics: marking its fortieth anniversary. *Am J Bioeth.* 2019;19(11):9-12. doi:[10.1080/15265161.2019.1665402](https://doi.org/10.1080/15265161.2019.1665402)
2. Williams GC, Deci EL. Internalization of biopsychosocial values by medical students: a test of self-determination theory. *J Pers Soc Psychol.* 1996;70(4):767-779. doi:[10.1037/0022-3514.70.4.767](https://doi.org/10.1037/0022-3514.70.4.767)
3. Williams GC, Deci EL. The importance of supporting autonomy in medical education. *Ann Intern Med.* 1998;129(4):303-308. doi:[10.7326/0003-4819-129-4-199808150-00007](https://doi.org/10.7326/0003-4819-129-4-199808150-00007)
4. Entwistle VA, Carter SM, Cribb A, McCaffery K. Supporting patient autonomy: the importance of clinician-patient relationships. *J Gen Intern Med.* 2010;25(7):741-745. doi:[10.1007/s11606-010-1292-2](https://doi.org/10.1007/s11606-010-1292-2)
5. Ryan RM, Duineveld JJ, Di Domenico SI, Ryan WS, Steward BA, Bradshaw EL. We know this much is (meta-analytically) true: a meta-review of meta-analytic findings evaluating self-determination theory. *Psychol Bull.* 2022;148(11-12):813-842. doi:[10.1037/bul0000385](https://doi.org/10.1037/bul0000385)
6. Vansteenkiste M, Ryan RM, Soenens B. Basic psychological need theory: advancements, critical themes, and future directions. *Motiv Emot.* 2020;44(1):1-31. doi:[10.1007/s11031-019-09818-1](https://doi.org/10.1007/s11031-019-09818-1)
7. Ng JYY, Ntoumanis N, Thøgersen-Ntoumani C, et al. Self-determination theory applied to health contexts: a meta-analysis. *Perspect Psychol Sci.* 2012;7(4):325-340. doi:[10.1177/1745691612447309](https://doi.org/10.1177/1745691612447309)
8. Ryan RM, Deci EL. *Self-determination theory: basic psychological needs in motivation, development, and wellness.* Guilford Publishing; 2017. doi:[10.1521/978.14625/28806](https://doi.org/10.1521/978.14625/28806)
9. Ryan RM, Deci EL. Brick by brick: the origins, development, and future of self-determination theory. In: *Advances in motivation science.* Vol.6. Elsevier; 2019. doi:[10.1016/bs.adms.2019.01.001](https://doi.org/10.1016/bs.adms.2019.01.001)
10. Sheeran P, Wright CE, Avishai A, et al. Self-determination theory interventions for health behavior change: meta-analysis and meta-analytic structural equation modeling of randomized controlled trials. *J Consult Clin Psychol.* 2020;88(8):726-737. doi:[10.1037/ccp0000501](https://doi.org/10.1037/ccp0000501)
11. Kors J, Martin L, Verhoeven CJ, Henrichs J, Peerdeman SM, Kusurkar RA. Autonomy support in prenatal consultation: a quantitative observation study in maternity care. *Eur J Midwifery.* 2025;9:1-11. doi:[10.18332/ejm/197053](https://doi.org/10.18332/ejm/197053)

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