Editorial

Rethinking Autonomy: Relationships as a Source of Resilience in a Changing Healthcare System

In the face of health system change, there is growing concern about the well-being of care providers and their ability to meet the needs of patients. Some scholars have called for expanding the goal of quality, access, and patient experience to a broader goal that includes the well-being of care providers themselves (Bodenheimer and Sinsky 2014). Scholars have found that stress at work is a source of job dissatisfaction, disengagement, burnout, and adverse health outcomes for employees, particularly for employees who feel they have little control (Karasek 1979; Parker and Sprigg 1990), and a source of negative outcomes for their clients as well (Schaubroek and Fink 1998; Gawande et al. 2003). As health care systems respond to pressures to provide higher quality care in an increasingly resource-constrained environment, there is a real risk of declining satisfaction and engagement for care providers and declining satisfaction for the patients they serve (Sexton, Thomas, and Helmreich 2000; Vincent et al. 2004).

But there are protective factors that create resilience in the face of stressful circumstances. Resilience is the capability to “recover from or adjust easily to misfortune or change” (Webster’s Collegiate Dictionary, 1987). It is the maintenance of positive adjustment under challenging conditions (Weick, Sutcliffe, and Obstfeld 1999), the ability to bounce back (Bunderson and Sutcliffe 2002), and the capacity to maintain functions and outcomes in the midst of strain (Edmondson 1999; Masten and Reed 2002). Resilience differs by individual and by workplace, and relationships play a role at both levels. Individuals with healthy, well-functioning relationships respond to the same stressful events with less negative impact on their well-being (Ryff and Singer 2002; Seligman 2002). In workplaces with healthy and well-functioning

relationships, employees respond to the same stressful events with less negative impact on their well-being (Carver, Scheier, and Weintraub 1989; Aiello and Kolb 1995; Moyle and Parkes 1999).

Building on a large body of social psychology research on relationships and resilience, relational coordination theory suggests that relationships create resilience through two different but complementary paths (Gittell 2008). One path is psychosocial, grounded in the relational nature of human identity. The other path is technical—grounded in the relational nature of work and the interdependence that arises from the division of labor. These two paths are related—our identities are constructed through our interactions with each other, including those that occur through the social division of labor (Durkheim 1893/1997; Follett 1949).

Defined as communicating and relating for the purpose of task integration, relational coordination supports psychosocial well-being under stress by enabling participants to share that stress with others, thus diffusing its impacts. This same set of communication and relationship dynamics influences quality and efficiency outcomes under stress by enabling participants to coordinate their interdependence, thereby overcoming tradeoffs and shifting performance frontiers outward to enable performance outcomes to be achieved with less friction and resistance. Some have described this relational type of coordination as a state of flow in which egos are relinquished in service of a clearly shared purpose, and actions are informed by collective purpose and collective mind, with respect for the contributions offered by each (Quinn and Dutton 2005). Previous studies have found relational coordination to be associated with positive outcomes for workers facing stress (Gittell et al. 2008; Havens et al. 2010; Warshawsky, Havens, and Knafl 2012; Havens, Warshawsky, and Vasey 2013; Albertsen et al. 2014; Naruse, Sakai, and Nagata 2016).

Despite the relevance of high-functioning relationships for achieving resilience in the face of stress—particularly when work is highly interdependent, uncertain, and time-constrained—it is not clear how these can be fostered in an industry where professional status has been associated with high levels of autonomy, and where professionals have been trained, selected, and rewarded to exercise high levels of autonomy. In the current issue of *Health Services Research*, “Resilience among Employed Physicians and Mid-Level Practitioners in Upstate New York” by Waddimba and coauthors provides a fascinating perspective on this very timely challenge. The authors contribute

to the debate by comparing relationships and autonomy as two alternative sources of resilience. Given the traditional autonomy associated with health care professions, particularly physicians, this comparison is apt. Given that autonomy is declining as we strive to achieve greater coordination for the sake of the patient experience and patient outcomes, it is also quite interesting to think of autonomy and relationships as two alternative sources of resilience. Indeed, some of the stress that care providers may be experiencing in the current system transformation is due to the loss of autonomy, and the pressure to become more interdependent without systems that effectively support interdependence.

The authors find that meeting one's autonomy needs is a predictor of resilience, but that relational needs trump autonomy needs in predicting resilience. There is much room for additional research on this topic, as the authors acknowledge, including the relative contribution of personal and professional relationships to resilience. We have learned from relational coordination theory and research that individual autonomy is inconsistent with high performance when the work itself is highly interdependent. Autonomy in the traditional sense is unattainable. When work is highly interdependent, only by managing our interdependence in a highly relational way, with opportunities to resolve our conflicts constructively, can we carry out our work with a sense of autonomy, through coordinated collective action (Gittell, 2016).

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