This article focuses on the development of a concept of shared autonomy. This concept is a result of rethinking the idea of autonomy against the background of a 2 phases research project in General Practice (GP). Observations of patient and doctor's behavior underlined the necessity of re-evaluating the idea of the patient's autonomy as directly related to the doctor's autonomy. In this article I will briefly present the research program, some results, and in the conclusion I will make some remarks on autonomy.

This first part of the research program was designed to clarify some patient factors related to the use of GP services. There was a special interest in non-medical factors in referral patterns. Fifty patients over 14 years old in 14 practices were selected at random over a period of 5 days. They were invited to fill out a paper and pencil questionnaire. The physicians filled out the same questionnaire about corresponding patients. The second phase of the research was based upon findings from the first phase, and consisted in observations in the waiting room and video-taping 135 doctor-patient consultations within the consultation room of 6 different practices (Bergsma et al. 1980, 1982).

PHASE I

The research model was a simple Input-Output model. The following questions were raised: (1) What is the composition of the input concerning age, sex, etc., and how is it related to the composition of the three output streams (referral, returning, back home)? (2) What is the relation between patient characteristics and physician's judgement? (3) Which patient-characteristics are significant for the output patterns?

The patient characteristics were defined as independent variables and consisted in four categories: (a) personal characteristics, (b) social characteristics, (c) person-related characteristics, and (d) sickness-behavior. The output variables were defined as dependent variables. The testing of significances was carried out by the Chi² method (5%) and afterwards several control analysis of variance were carried out.

RESULTS IN BRIEF

There were no real significant differences in the input-output patterns over
the 14 practices. The results also confirm findings in earlier research in Dutch practices (Verhoeff 1979). Out of 700 patients 428 were female, 253 male (197). The mean age was 38.6 (s.d. 16.5). 43% only received a basic education, 44% of the patients continued their education on middle-level, and 13% had a university education.

The mean frequency of visiting the GP is 4.2 a year. This is consistent with earlier findings. 73% of the patients were on social health care; 24% had a private insurance. The relation between output and input pattern creates the first real problem for design and theory. Besides a referral percentage of ± 12% and an incidental consult in ± 28%, roughly 65% of the patients had to return back to the GP, half of them on a fixed appointment suggested by the physician. The other half were encouraged to come back but the initiative for the appointments remained theirs. With such a high percentage of returning patients the input is no longer an independent complex of variables. The input seems to be largely dependent on the output. The consequence is that the linear research model should rather be a circular model, because it reflects reality much better. The circular interactional model seems to be a much better model in healthcare research than the often used linear model (Bergsma 1982).

Within the circular stream of patients we found significantly more people with only a basic education. Female patients, especially between 35 and 54, tend to have more new appointments than male patients. They also have a higher frequency of visiting; surprisingly this leads to more fixed dates with the physician.

Male patients, especially those with continued education tend to leave the circle very early because of a referral or no new appointment. Patients with a lower visiting percentage (once per 6 months or less) tend to get more referrals as a consequence of physical complaints. Patients within the circle more often are diagnosed as 'psychosocial'. They have a significantly lower referral percentage. An over-all finding was that patients with a high consulting frequency, about 20% of them, covered more than 65% of the physician's consulting time. Patients as well as the physicians were asked to estimate the frequency of consulting. In cases of a high consulting frequency (once a month or more, once in three months or more) physicians overestimated and patients underestimated the frequency. In cases of a frequency of once per 6 month or less, the patients tended to overestimate and the physicians to underestimate the frequency of visits needed.

A comparison of the reasons for consultation reveals that physicians and patients agreed on average less than 50% of the time. Another important finding was that in the differentiation between referrals and new appointments the educational level of the patient had a much more determining role than did the insurance contract. This finding is a confirmation of discoveries by Duff and Ross in the United States (Duff and Ross 1982).