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The patient, the doctor, and the patient's loyalty:

a qualitative study in French general practice

Abstract

Background
The term loyalty can be defined as the attachment that characterises someone who consistent in their feelings, affections, or habits. By introducing the Declaration of General Practitioner (or preferred doctor declaration) in 2004, France adopted a formal incentive for patients to be faithful to their doctor since it entailed optimal coverage of medical care by their national health insurance There has been no research evaluating the impact of this measure and to determine the components of doctor–patient loyalty.

Aim
To explore what builds and maintains patients' loyalty to their GP.

Design and setting
Qualitative study based on semi-structured interviews close to Paris (the département of Yvelines'), France.

Method
Twenty-eight patients were interviewed in five surgeries of self-employed GPs with different demographics. Interviews were transcribed and a thematic analysis conducted to categorise the data. Phenomenological analysis was used to analyse the transcripts.

Results
Patient loyalty is based mainly on trust. Trust can be reinforced by certain comforting factors such as the ability to listen, a sense of carefulness, and the quality of care. Loyalty is both a dynamic construct and a relational exchange subject to various influences. Patients find advantages in being loyal. The model of the 'family doctor' has always been the archetype of loyalty for several generations within one family. A GP's inability to meet all of the patient's requirements is not necessarily a determining factor in breaking the patient's loyalty.

Conclusion
Loyalty is more complex than commonly assumed and involves dimensions of trust, listening, quality of care, availability, and familiarity. The observations drawn out from this study warrant a larger scale investigation.

Keywords
continuity of patient care; doctor–patient relations; general practice; qualitative research; trust.

INTRODUCTION

Continuity of care and of doctor–patient relationship is key to general practice.[1] The creation of a bond is something patients care about.[2,3] The maintenance of the relationship over time may be influenced by the concerns and psychological vulnerability of the patients, as well as their perception of the qualities of their GP.[2,4–6] This relationship has an impact on how the patient is taken care of and on the quality of the treatment. It develops gradually and is linked to the concept of loyalty.[7]

Loyalty is defined as the attachment that characterises someone consistent in their feelings, affections, or habits.[8] It can be the quality of a feeling that is not altered by time. Loyalty is a concept that also has limits and weaknesses.

Several studies have shown that loyalty towards the GP increases with the patient's age and the existence of a chronic pathology, but lowers with higher academic level. Pensioners and patients with unstable employment are more loyal than those with stable employment.[6,9,10]

In France, the Caisse d'Assurance Maladie (public health insurance fund) sees coherence in maintaining the doctor–patient relationship in terms of efficiency and healthcare costs. Since the law of August 2004 reforming health insurance, this institution has brought an administrative element to this relationship. This law reforming health insurance brought about a new organisation of health care: patients who want optimal coverage of their care by national health insurance must choose a preferred doctor who is responsible for coordinating their contacts with specialists (it is referred to here as 'preferred doctor declaration') (Appendix 1).[11,12] It encourages patients to choose one GP and imposes financial sanctions if they fail to do so, thus giving value to this relationship and making the patient's loyalty official. However, there has been no research to determine the components of doctor–patient loyalty, and there are few data regarding this topic. The aim of this study is to explore what creates and maintains patients' loyalty towards their GP.

METHOD

Study design
This was a qualitative study based on semi-structured interviews where 28 patients were interviewed in five surgeries of self-employed GPs with different demographics. Interviews were transcribed and a thematic analysis conducted to categorise the data and a phenomenological analysis was used to analyse the transcripts.

Recruitment and sampling
A purposive sample was studied, including patients of varying age and both sexes, suffering from different chronic or non-

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How this fits in

To the authors' knowledge no previous studies have been conducted on what builds and maintains a patient's loyalty towards their GP. The present study shows that this is a complex phenomenon, based on many elements both subtle and identifiable. However, some factors, specific to each patient are necessary to maintain the continuity of the relations.

chronic conditions in several medical practices. The sample size depended on obtaining data saturation.

Practices were selected taking into account the medical demographics (number of GPs per 10 000 inhabitants of a living area), the socioeconomic status of the area, the date of creation of the practice, the sex and age of the GP, the type of fee agreement that the GP signed with the national health insurance scheme, and the organisation of consultations (with or without appointment). The date the practice opened was taken into account because it was assumed that the duration of the prior relationship demonstrates patients' loyalty. Therefore it could be considered that patients of newly-established doctors could be less loyal (having been cared for by the GP for a shorter period) than those belonging to older practices.

Seven practices from the 'département of Yvelines' (north-west of Paris) were contacted, five of which agreed to participate in recruitment of patients. Participants were interviewed in waiting rooms or other private rooms to guarantee confidentiality and anonymity. The purpose of this study and interview process were explained to the patients.

Data collection and analysis

An interview guide was prepared by the study investigators. It included open questions; the order and the wording may have varied from one patient to another. The topics addressed were chosen based on data from the literature and test interviews.[2,4–6,9,13–15] About 15 topics were selected (Boxes 1 and 2).Interviews were conducted between March and July 2015 and the interviews were carried out until data sufficiency was confirmed.

The patients agreed to have the interviews digitally recorded, the latter then being transcribed entirely before being destroyed. Transcripts were read several times by two different researchers. First, a thematic data reduction was performed and then a verbatim reports were divided into units of meaning. Two continuous thematic analyses were conducted on two different software programs: N Vivo (version 9) and RQDA.

Themes were grouped into classificatory headings, allowing for the development of a topic tree and creation of categories. The comparison of the two analyses was made using an approach of validation through triangulation, to increase the validity of the study and the quality of results.

Phenomenological analysis was used to analyse the transcripts. This was to make meaning of the experience of the patient, and to make an empathetic reformulation.[16] Quotes most illustrative of the statements were chosen; these were also the more meaningful quotes.

RESULTS

Population characteristics

Twenty-eight semi-structured interviews were produced. The duration of the interviews varied from 14 to 48 minutes, with an average of 24 minutes.

The patients came from different socioeconomic backgrounds (eight males and 20 females, with an average age of 49.7 years) (Table 1). Patients were treated by 11 doctors (seven males and four females) in five different practices. One medical office was shared by two associate doctors, while another was a medical centre where six GPs worked. Interviews were conducted around consultations with five different doctors.

GPs were aged between 32 and 60 years old (Table 2). All patients declared they have previously chosen a preferred GP.

Results of the analysis

The analysis showed nearly 200 different

Box 1. Themes of the interview guide

- Consulting with another GP: circumstances, reason, opinion
- Medical nomadism (a patient consulting several doctors in a short span of time for the same complaint): definition, opinion, impact
- Reform of the preferred doctor scheme: impact, commitment
- Child consultations
- Care consumption behaviour in childhood
- Family doctor
- Relationship with the GP
- Quality of service given by the GP
- Patient loyalty
- Reaction towards refusal from the doctor
- Choice of the GP: circumstances, opinion
- How the consultation is carried out
- Follow-up
- The medical file
- *Carte Vitale* (health insurance card evidencing the health insurance claims and allowing reimbursement for care)

Box 2. Interview guide questions

1. **Over the last 12 months, have you consulted a doctor other than your preferred doctor?**
   If so:
   - How many different GPs have you seen?
   - On what occasions? For what reasons?
   - Had you consulted your doctor for the same reason?
   - Did you get something from the consultation with the doctor?
   - You saw several GPs; can you tell me how it went?
   - Do you think that your relationship with the doctor is different because it is not your preferred doctor?
   - Do you think that the way you are taken care of is different?
   - I guess that there were differences; what did you notice?
   - What could be different in the practice of a GP other than your preferred doctor?

   If not:
   - Have you ever consulted a GP other than your preferred doctor?
   - Never ever?
   - Why?

   If never:
   - What do you think about going to see a GP other than your preferred doctor?
   - What could lead you to go to another GP?
   - What could be different in the practice of a GP other than your preferred doctor?
2. **I would like to address the topic of medical nomadism.**
   - What does it mean to you?

   Medical nomadism describes a patient consulting several doctors in a short span of time for the same reason.
   - What do you think about this?
   - What could lead you to go to another GP?
3. **Since 2004, you are asked to report a preferred doctor. For this, the patient and the doctor have to jointly sign a form.**
   - How has this changed your behaviour?
   - How did the declaration of preferred doctor change the relationship with your doctor?
   - In your opinion, what is the point in having formalised the relationship?
   - How does it represent a commitment?
4. **For your children, do you consult several doctors?**
   - Paediatricians? GPs?
   - Why?
5. **When you were a child, would you always go to the same doctor?**
   If not, why?
6. **What does the term 'family doctor' mean to you?**
   - Are you looking for the same thing with your doctor?
   - How would you describe your relationship with your doctor?
   - What are the qualities of your doctor?
   - What do you think he/she is lacking?
7. **Have you ever been tempted to visit another GP?**
   - If so, why?
   - If not, why not?
   - What might prevent you to consult another GP?
8. **Would you say that you are a loyal patient?**
   - What does being a loyal patient mean to you? Could you define the term?
   - Could it be similar to the faithfulness of a couple? What does it imply? Is it a commitment?
   - Do you have this type of commitment with other professionals (for example, specialists, dentist, hairdresser?)
   - Are there any nuances or differences depending on the professionals?
   - Do you think that the professional benefits from your loyalty?
   - Do you think that your being loyal affects the action of the doctor?
9. **If one day your doctor denies you something you really want, how would you behave?**
   - In which circumstances?
10. **In some countries, patients do not choose their GP; what do you think about this?**
    - How did you choose your GP?
    - Have you consulted other doctors before choosing him as your doctor?
    - Why have you chosen this GP as your preferred doctor?
    - Could you tell me about your first meeting with your current doctor?
    - What did you like?

... continued.

themes. Box 1 contains the 15 topics discussed during the interview. After the data was categorised they were grouped into the categories presented below.

Patient's loyalty is based on trust. The basis for developing and maintaining loyalty is the trust placed in the doctor:

'A loyal patient, referring to what he feels towards his doctor, is a matter of trust and that's all.' (Interview [I]21, male [M], 67 years)

This element of trust could stand on its own or be stabilised by various elements such as availability, a caring attitude, quality of care, and the interest shown to the patient. Trust enabled the patient to confide in the doctor and allowed for more freedom of expression. It improved compliance and acceptance of refusal (such as refusal of treatment, prescriptions, stopping work, referral for imaging examination, or consultation with a specialist):

'If you trust your doctor, you can tell him anything.' (I3, female [F], 76 years)

Truth is specific and related to the person. It was a dynamic phenomenon depending on the duration of the doctor–patient relationship. By inciting patients to always consult the same doctor, the reform of the preferred doctor scheme reinforced that bond.

Loyalty and trust were inseparable. There could be no loyalty without trust and in the same way, loyalty strengthened confidence:

'On the first consultation we meet, then on the second and third one, it becomes normal, confidence settles in and that's it.' (I21, M, 67 years)

Loyalty is a dynamic construct: from the first exchange to a final recognition. Recognition here refers to treating the patient with respect and remembering their situation and history. Loyalty would be established with time. Throughout the consultations, it became a source of memory, identification, and knowledge. Mutual knowledge between the patient and the doctor would result in loyalty.

The doctor, over time, would assimilate the medical history and intimate life of the patient. This knowledge was an element of understanding and adaptation that improved the relationship between the doctor and the patient, and helped for better care. It would give the doctor greater analytical and comprehension capabilities. Treatments

Box 2 continued. Interview guide questions

11. Could you tell me about the way that the consultation with your doctor is held?

- What do you like?
- What are your expectations?
- What is most important to you in the consultation?
- How long do you think the consultation lasts?
- Do you have a chronic illness followed by your GP?
- Why is this follow-up important to you?
- Does your doctor write in your medical record?
- In what form (paper or electronic)?
- In your opinion, what does he/she note in your record?
- How important to you is your medical record?
- Do you use your *carte Vitale*? (health insurance card)
- According to you, what is the use of the *carte Vitale*?
- In your opinion, how could it serve as a mean for the follow-up of patients?

12. What do you think are the possible impacts of visiting several GPs?

- What are the interests or benefits?

13. What do you think are the possible consequences of consulting several GPs?

- What do you think of the impact on health?
- What do you think of the cost for the health system?

14. Do you have anything to add about your relationship with your doctor?

would be more appropriate and easier to provide:

'A good doctor is a doctor that can see what is wrong with you because he knows you well.' (I11, F, 44 years)

The medical record was used as a link and proof of loyalty. Its value depended on personal representations:

'My entire life is recorded in these files.' (I1, F, 41 years)

The importance of the medical history and the number of treatments carried out, as well as the length of the period of follow-up reinforced the bond. The record, combined with the assumed integration ability of the data that it contained (that is, adaptation of the care according to the data), increased the patient's loyalty because of the impact on the care provided by the doctor.

Loyalty improved follow-up, and in the same way, follow-up helped develop loyalty. The importance attached to the follow-up was related to the vulnerability of the patient.

Loyalty is a relational exchange subject to multiple influences. The development of loyalty depended on elements specific to the patient, to the doctor, and also to their relationship. Loyalty was influenced by their personality and habits. For some, it was a high principle of life, and even a universal virtue. It could also be an expression of a reassuring ritualised behaviour:

'Actually, I am loyal by nature.' (I27, F, 42 years)

Patients tended to reproduce a relational scheme known since childhood and related to maternal behaviour in terms of care consumption:

'Oh yes, my mother and I used to see the same doctor.' (I18, F, 57 years)

Patients' satisfaction with their GP was a key factor in the doctor–patient relationship and it was critical to maintain it. Loyalty was based on perception of subjective elements and of details the patient felt:

'Everything is based on whether or not I feel good talking to the person in front of me, and that would make me want to come back.' (I19, F, 32 years)

That patients persist in going to the same GP introduced the notion of commitment. This could be related to trust and would not necessarily have to do with administrative obligations, or exist as a result of the signing of a preferred doctor declaration form:

'Trusting him, it is a commitment.' (I15, F, 47 years)

The preferred doctor declaration generally represented an administrative formality. It could also be seen as a way to create and maintain loyalty:

'With the paper, it looks as though they are trying to make us come back.' (I23, M, 75 years)

Nonetheless, the impact of this reform on maintaining loyalty remained negligible:

'I already had a doctor whom I was seeing and to whom I was loyal. Nothing changed.' (I24, F, 76 years)

The preferred doctor declaration, although the expression of a pre-existing reality, was a kind of formalisation of the relationship or, even, a pledge of loyalty:

'It's a loyalty pledge between us; we think he is our doctor of reference, and we come back to him because that is where we said we would go.' (I17, F, 37 years)

The possibility to change their practitioner at any time had been clearly identified. For the patient to be loyal, the doctor had to have certain qualities such as kindness

Table 1. Patient characteristics

Interview	Sex	Age, years	Family situation	Children, *n*	Profession	Chronic disease followed by GP	Length of relationship
I1	Female	41	Married	3	Housewife	No	10 years
I2	Female	56	Married	3	Accountant	No	4 years
I3	Female	76	Married	3	Pensioner, was nurse	Yes	20 years
I4	Male	63	Married	2	Unemployed, delivery driver	Yes	3 months
I5	Male	42	Civil partnership	0	Industrial waste manager	Yes	3 months
I6	Female	31	Separated	2	Teacher	Yes	15 years
I7	Female	38	Single	1	Executive assistant	No	8 years
I8	Female	54	Divorced	3	Social worker	No	15 years
I9	Male	68	Married	2	Pensioner, supervisor	Yes	7 years
I10	Female	77	Widow	0	Pensioner, accountant assistant	Yes	10 years
I11	Female	44	Married	2	Quality manager	No	15 years
I12	Male	48	Cohabiting	3	Bank employee	No	15 years
I13	Male	56	Single	0	Unemployed	Yes	15 years
I14	Female	66	Married	1	Pensioner, medical secretary	Yes	3 years
I15	Female	47	Married	3	Recreation centre director	No	30 years
I16	Female	51	Widow	2	Domestic help	Yes	9 months
I17	Female	37	Married	0	Human resources director	Yes	22 years
I18	Female	57	Single	4	Restoration agent	Yes	3 years
I19	Female	32	Married	1	Hostess	Yes	5 months
I20	Male	50	Married	2	Truck driver	No	1.5 years
I21	Male	67	Single	0	Pensioner, logistics	No	1 year
I22	Female	44	Married	3	Domestic help	No	2 years
I23	Male	75	Married	2	Retired, technician	Yes	1.5 years
I24	Female	76	Married	2	Pensioner, inspector of education	Yes	1.5 years
I25	Female	65	Widow	2	Pensioner, caretaker	No	2 years
I26	Female	20	In a couple	0	Student in mechanics	No	2 years
I27	Female	42	Married	1	IT project manager	No	2 years
I28	Female	18	In a couple	0	Student	Yes	7 months

and patience. Empathy, an emblematic intrinsic virtue, favoured loyalty. Skill and professionalism were also essential to maintain loyalty. The attitude of the doctor, the consideration given to the patients, and the ability to adapt also helped in the development of the doctor–patient relationship:

'When you see your GP, it looks like you are the most important person who will be taken care of. That is the feeling I get, and I like it.' (I27, F, 42 years)

Good social skills are necessary to build loyalty and vice versa. It is based on communication skills, the ability to exchange views, and the attention given to the patients. The lack of any of these qualities would undermine the doctor–patient relationship. Patients want to be able to trust and rely on their doctor. They emphasised the importance of medical assistance in delicate situations:

'A good doctor–patient relationship helps to get through your problems.' (I14, F, 66 years)

Patient's loyalty helps to create contact and access to health care. Patients who were aware of the advantages entailed maintained their loyalty:

'Going to the same doctor for any medical issue is what loyalty is all about.' (I15, F, 47 years)

Patients recognise the benefits in being loyal. Maintaining loyalty requires suitable material conditions (closeness of the medical office, availability and punctuality of the GP). Adapting the duration of the consultation according to the patients' requirements played a part in the development of loyalty. The time spent showed that interest was displayed towards the patient and the doctor was truly involved:

'She takes her time, she doesn't throw us out.' (I2, F, 56 years)

One of the main concerns of the patients

Table 2. GP characteristics

Medical office/GP	Sex	Age, years	Duration of establishment, years	Number of GPs in the medical office	Medical demographics density	Type of area and population	Appointment needed	Fees
Surgery 1	Female	49	20	1	High	Urban free zone	Yes	Regulated
Surgery 2	Male	60	15	1	Low	Semi-rural	Both	Free
Surgery 3	Male	60	29	2	Medium	Urban, mixed	Yes	Regulated
Surgery 4	Male	32	1	1	Medium	Urban free zone	Yes	Regulated
Surgery 5	Female	32	2	6	High	Urban, upper class	Both	Regulated

was how well they were treated medically. This has an impact on how well things went between the doctor and the patients. Patients thought that the more they consulted the same GP, the better and faster the treatment received. Repeated consultations enabled better knowledge of the patient's situation and led to better diagnostics:

'He is going to know everything about my history, which means he will make a better diagnosis.' (I27, F, 42 years)

Fidelity helped in receiving personalised care. The prescription was considered more appropriate when there was an established medical relationship between patient and doctor:

'They know our medical history; it allows to be more accurate with prescriptions.' (I6, F, 31 years)

The doctor's explanations and advice are important in developing the relationship as well as the care provided, they helped maintain the relationship. The quality of answers provided by the GP with regards to the needs and issues of the patient were equally essential:

'A loyal patient? That would be someone who gets all the answers when seeing his doctor.' (I9, M, 68 years)

The 'family doctor' has been the archetype of loyalty for generations. The patient's bond with the doctor is particularly strong. The doctor was allowed within the family unit. Hence, fidelity became implicitly natural:

'He's like family to us.' (I23, M, 75 years)

The family doctor was assumed to have great knowledge of each patient, their medical history, and background. The doctor is also the keeper of the family's memory. The relation with the family doctor is naturally set in time, over several generations. They became then a reference for the family in terms of health care, implying loyalty over generations.

Several patients felt nostalgia, linked to their childhood, when considering the family doctor. The GP's presence symbolised stability throughout one's life.

The inability to meet the patient's requirements does not necessarily mean breaking their loyalty. Although the patient considered themselves loyal they would sometimes see another GP. In some cases, the patient had their reasons for this (such as urgency felt or travel), whereas in other cases it had to do with the doctor (such as unavailability, refusal of an important demand, or a specific competence required):

'This is in case I am not here and if there is an emergency.' (I2, F, 56 years)

These were rare situations that had no impact on the patients' loyalty. The patients would understand the situation in case of unavailability of the GP:

'Afterwards, I would see my regular GP anyway.' (I19, F, 32 years)

The search for a second opinion, a delicate illness or a fear of disappointing their preferred doctor (for example, when discussing difficult subjects such as alcohol consumption) could also explain why patients consulted an alternative GP.

Reasons leading to the loss of loyalty of a patient and to a change of doctor included: retirement of their regular doctor, a change of location, a loss of interest felt by the doctor for his patient, or a medical error:

'Because my previous doctor moved away.' (I19, F, 32 years)

'I was not satisfied. I did not feel comfortable. I felt like I was bothering him.' (I25, F, 65 years)

DISCUSSION

Summary

This qualitative study is one of the first (to the authors' knowledge) to study the various aspects of loyalty in a doctor–patient relationship. It was noted that construction of loyalty is a complex, multifaceted phenomenon. Trust is essential, whether alone or strengthened by elements such as the ability to listen, the attention given, and the quality of care. Trust and loyalty are intertwined. Knowledge of the patient's background and of their medical record allows for personalised treatment, which encourages loyalty. Maintaining this relationship was linked to the balance between patient expectations, depending on their personality, their expectations of a doctor and what the doctor could offer.

The GP's availability, as well as the image of the family doctor present since childhood, also encourages loyalty.

Strengths and limitations

This is the first qualitative study that has specifically examined the elements of the

construction and continuance of loyalty. It was based on important discursive material and on a varied sample.

Additional reminders could have been carried out to clarify the testimonies. Some questions overlapped, recurrent themes could have guided the patients 'answers.

To minimise the risk of bias and interviewing only patients loyal to, or having a positive opinion of, their GP, patients were not informed of the content of the questions when they were approached. Recruitment took place in the waiting room before or after the consultation and patients with no follow-up (those who consult several different doctors, or the same doctor but irregularly), or who were not consulting, were not interviewed.

The analysis was performed by doctors; the data could be interpreted favourably towards other doctors. The point of view of a sociologist would have been useful as they would have a neutral point of view and would probably be more objective.

Comparison with existing literature

The concept of loyalty is only meaningful in the context of a healthcare system that allows a choice of doctor. Most studies on continuity of care, however, were carried out in countries in which the choice is subject to stricter rules and is more restrictive.[4,5,17,18]

Previously, it has been reported that trust encourages loyalty.[13–14] In the present study, this appeared essential to creating and maintaining loyalty. It has also been reported that the longer the doctor–patient relationship has been held, the higher is the confidence level.[19] It was demonstrated, however, that the continuity of the relationship is not in itself sufficient to ensure the development of trust. This depends on other elements, such as interest shown by the doctor to the patient, and the quality of care.[17] Analysis of the transcripts from the present study highlighted that the opposite was true: trust, although essential, does not always enable on its own the development of loyalty. Other elements are sometimes needed to stabilise or reinforce it. It is reciprocal. In both situations, other elements are sometimes necessary.

The link between personal continuity and satisfaction level has already been proven in other case studies.[6,7,15] The duration of the doctor–patient relationship was significantly associated with the patient's satisfaction level.[20] Another study showed, however, that satisfaction and continuity are not always linked. However, the combination of recognition and continuity actually generated added value in interpersonal doctor–patient relationships throughout the consultations.[21] The present study confirmed this by showing that satisfaction helped with establishing loyalty but its continuity was usually dependent on many factors.

The significance for the patient to create a bond was identified and this need for a referential link relates to attachment theory.[2] Patients approached their preferred doctor when they had health problems and they felt they were better taken care of when they were loyal to their doctor. A study has shown that 'less' personal care was perceived as less effective.[22] This view was shared by GPs who felt they could provide better care when the relationship had been established over time.[17]

Implications for research and practice

This study improves our understanding of patient loyalty, and the doctor–patient relationship and as such, should be encouraged. Loyalty would be a criterion for improving care but further research is required to determine whether loyalty indicates good care. A quantitative study may specify the significance of each element found in maintaining patient loyalty. A study examining the views of doctor's on patient loyalty and what it means to them would also be interesting and beneficial.

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REFERENCES

1. WONCA Europe. *La Definition Europeenne De La Medecine Generale — Medicine De Famille*. [The European definition of General Practice - Family Medicine]. 2002. http://www.woncaeurope.org/sites/default/files/documents/WONCA%20definition%20French%20version.pdf (accessed 30 Sep 2016).
2. Frederiksen HB, Kragstrup J, Dehlholm-Lambertsen B. Attachment in the doctor–patient relationship in general practice: a qualitative study. *Scand J Prim Health Care* 2010; **28(3):** 185–190.
3. Feuillet A. Why do patients change their general practitioner? qualitative survey of patients of Eure et Loir. [Dissertation]. [In French]. Tours: Université François Rabelais, 2013. http://www.applis.univ-tours.fr/scd/Medecine/Theses/2013_Medecine_FeuilletAnais.pdf (accessed 30 Sep 2016).
4. Rhodes P, Sanders C, Campbell S. Relationship continuity: when and why do primary care patients think it is safer? *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X682825.
5. Cocksedge S, Greenfield R, Nugent GK, Chew-Graham C. Holding relationships in primary care: a qualitative exploration of doctors' and patients' perceptions. *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X588457.
6. Pandhi N, Saultz JW. Patients' perceptions of interpersonal continuity of care. *J Am Board Fam Med* 2006; **19(4):** 390–397.
7. Hjortdahl P. Continuity of care — going out of style? *Br J Gen Pract* 2001; **51(470):** 699–700.
8. Larousse. French dictionary; fidelity definition. [In French]. Paris: Editions Larousse, 2015. http://www.larousse.fr/dictionnaires/francais/fid%C3%A9lit%C3%A9/33599 (accessed 30 Sep 2016).
9. Mousel C. *The general practitioner in 2007, evolution in 25 years the image of the practitioner and patient expectations. Results of a survey of 108 subjects of Fensch Valley and Haut Pays Lorrain*. [In French]. Nancy: Université Henri Poincaré, 2009.
10. Rundle-Thiele S, Russell-Bennett R. Patient influences on satisfaction and loyalty for GP services. *Health Mark Q* 2010; **27(2):** 195–214.
11. Law No. *2004-810 of 13 August 2004 concerning health insurance. Article 7. Published in JORF n°190 2004–08–17: 14598*. [In French]. Legifrance Paris, 2015. https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000625158&dateTexte=&categorieLien=id (accessed 30 Sep 2016).
12. Le Fur P, Yilmaz E. Referral to specialist consultations in France in 2006 and changes since the 2004 Health Insurance reform. 2004 and 2006 Health, Health Care and Insurance surveys. *Questions d'Économie de la Santé* 2008; **134**. http://www.irdes.fr/EspaceAnglais/Publications/IrdesPublications/QES134.pdf (accessed 28 Sep 2016).
13. Ipsos Public Affairs. *The good image of GPs*. [In French]. Paris: Ipsos, 2007.
14. Torres E, Vasquez-Parraga AZ, Barra C. The path of patient loyalty and the role of doctor reputation. *Health Mark Q* 2009; **26(3):** 183–197.
15. Platonova EA, Kennedy KN, Shewchuk RM. Understanding patient satisfaction, trust, and loyalty to primary care physicians. *Med Care Res Rev* 2008; **65(6):** 696–712.
16. Paillé P, Mucchielli A. *Qualitative analysis in human and social sciences*. [In French]. 3rd edn. Paris: Armand Colin, 2012, pp.139–155.
17. Tarrant C, Dixon-Woods M, Colman AM, Stokes T. Continuity and trust in primary care: a qualitative study informed by game theory. *Ann Fam Med* 2010; **8(5):** 440–446.
18. Ridd M, Shaw A, Salisbury C. 'Two sides of the coin' — the value of personal continuity to GPs: a qualitative interview study. *Fam Pract* 2006; **23(4):** 461–468.
19. Mainous AG 3rd, Baker R, Love M, *et al*. Continuity of care and trust in one's physician: evidence from primary care in the United States and the United Kingdom. [Abstract]. *Fam Med* 2001; **33(1):** 22–27.
20. Hjortdahl P, Laerum E. Continuity of care in general practice: effect on patient satisfaction. *BMJ* 1992; **304(6837):** 1287–1290.
21. Frederiksen HB, Kragstrup J, Dehlholm-Lambertsen G. It's all about recognition! Qualitative study of the value of interpersonal continuity in general practice. *BMC Fam Pract* 2009; **10:** 47.
22. Schers H, van den Hoogen H, Bor H, *et al*. Preference for a general practitioner and patients' evaluations of care: a cross-sectional study. *Br J Gen Pract* 2004; **54(506):** 693–694.

Appendix 1. The French healthcare system

The French healthcare system is a universal healthcare system largely financed by the government national health insurance. Most GPs work in a private practice. The patients are invoiced by the doctor for fees and then reimbursed up to 70% for most healthcare costs. Additional health insurance cover can be purchased from private insurers, insurers, and mutuals. Patients with diseases identified as serious diseases (limiting list of 30 illnesses) are supported at 100% by the 'Public fund'.

Until 2004, each patient was free to directly consult a specialist. The law of August 2004 reforming health insurance brought about a new organisation of health care based on two principles in particular: the preferred doctor and the coordinated healthcare circuit. These were applied in full on 1 January 2006. Patients who are ≥16 years old who want optimal coverage of their care by national health insurance must choose a preferred doctor who is responsible for coordinating their contacts with specialists (this is the preferred doctor declaration). The system offers free choice of the reference doctor, which is not restricted to GPs.

Patients can still consult specialists directly but they will then be reimbursed less, except for gynaecologists, ophthalmologists, or psychiatrists who are not subjected to a financial penalty. Such access is known as a specific direct access. As costs are borne by the patient and then reimbursed, patients have freedom of choice of where to receive healthcare services.

Patients can consult any doctor directly under certain circumstances such as in an emergency, when far from home, if the preferred doctor is absent.