

# The Physician-Patient Relationship in the Context of Fibromyalgia. Tribulations and Proposals

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No other clinical entity causes as much controversy in the rheumatologic community as fibromyalgia (FM). It is clear that some physicians feel aversion to this nosologic entity. This rejection stems to the scarce knowledge on the mechanisms that unleash and perpetuate the illness as well as the frustration derived from the constant therapeutic failures. The challenge that FM represents in our days has been recently exposed on an editorial in the *Revista Española de Reumatología*, by one of the most distinguished persons in international rheumatology, Dr Jaime Rotes Querol.<sup>1</sup> In his article, several reasons are discussed by which the patient-physician relationship can deteriorate in the presence of FM. He also proposes several means to improve this. Some of the opinions exposed below arise from scientific evidence, others are just personal observations. There is no pretense for certitude in this discussion, only the intention to make a modest call to reflection. One must first remember the therapeutic complexity in the treatment of chronic illness, which, by definition, is incurable. In these circumstances, the physician must accompany the patient for years, trying to provide an acceptable quality of life in spite of the disease. Neither the patients nor the physicians have the satisfaction of achieving a cure. Furthermore, the physician has to deal with the understandable demand of the patients to attain a better quality of life. The situation is even more complicated if the patients chief complaint is pain. Persistent pain necessarily has a negative emotional impact. Although FM is a controversial illness, its frequent presence in the rheumatologists' office is beyond any discussion. The consensus document of the Sociedad Española de Reumatología qualifies FM as "a public health problem of the first magnitude."<sup>2</sup> Maybe it could also be characterized as a fundamental women's health issue.

I have to mention that several of the reasons that favor this deterioration in the patient-physician relationship in FM and to expose the possible remedies.

- Lack of knowledge. Little is known about the ethyopathogenesis of FM. The physician confronts an array of symptoms: diffuse pain, fatigue, insomnia, depression, intestinal irritation, urinary urgency, anxiety, depression, etc. The physician does not have a theoretical basis to form a coherent syndrome. The resource of analysis does not help in these circumstances to clear the problem up.
- Incredulity. It tends to be an attitude derived from the lack of knowledge on the illness. Some physicians simply do not believe what the patient is telling them or try to "correct the situation." They tell the patient (or simply think it): "You do not have pain, you are simply projecting your anxiety." The patient frequently perceives this and resents the incredulity.
- Lack of training in the basic mechanisms of chronic pain. There is an undeniable paradox in the rheumatologic practice. The chief complaint in the immense majority of patients that go to the rheumatologist is chronic pain. Nonetheless, this topic is not covered in most teaching programs in rheumatology. One only has to review the specialty textbooks to see that they have large chapters covering the basic mechanisms of inflammation and autoimmunity but in contrast, the discussions on chronic pain (when present) are brief and superficial.
- Psychological impact. Chronic pain is necessarily accompanied by a negative emotional reaction. Besides, a considerable percentage of persons with FM have anxiety, depression or other psychological alterations. This type of co morbidity complicates patient-physician relationships and therapeutics.
- Restricted timeframe in the outpatient clinic. Patients with FM have multiple symptoms; the physician has very little time and, apart from that, has other patients waiting. It is a sure formula for frustration both in the patients case and in the physicians case.
- Ineffective medication. We do not have uniformly effective medicines. With the chronic use of drugs, the appearance of undesirable effects is common. It is not rare to hear the patient state that: "The medication you prescribed not only did not improve my situation, they made me worse."

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## Possible Remedies

- Research. Clearly the only remedy for the lack of knowledge about the ethyopathogenesis of FM is research.

Other attitudes such as rejection, indifference, or discrimination are undignified in a climate of scientific and humanistic medicine. In the past, the rheumatologic community has shown audacity when exploring sister disciplines with the objective of better understanding its own diseases. This has been the case of research into immunology to improve the understanding of rheumatic disease of the closeness with vascular surgery to confront antiphospholipid syndrome. To better understand FM, it is necessary to delve into the territories of neurology, pain medicine and psychiatry.

– Teaching. It is imperative to include chronic pain as a fundamental field in rheumatologic curricula. The rheumatologist must be familiar with the modern concepts of neural plasticity, sensibilization of the central pain pathways, inhibitory descendant mechanisms, neuropathic pain, etc. In this sense it is important to recognize that the Sociedad Española de Reumatología is lighting the way. With an audacious initiative that is without precedent in the international rheumatology community, it has instituted the “school of pain,” a theoretical and practical course for rheumatologists that has the aim to delve into and update the knowledge of chronic pain.

– Adopting new nosologic paradigms. It is necessary to recognize that certain current models, such as anatomic-clinical correlation and the nosologic dichotomy between physical and mental illness, are not applicable to FM. Neither is it applicable to other syndromes that are very frequent in the clinical practice such as migraine, chronic fatigue syndrome, or interstitial cystitis, among many others. Therefore it is convenient to assume that, as was recognized by the classical French clinicians, what finally defines an illness is not organic damage but dysfunction.<sup>3</sup> A structural lesion without dysfunction is not disease. Terminating the Cartesian body-mind dichotomy and adopting a bio psychosocial model of disease that is patient-centered.

– Working with a coherent theoretical background. New evidence supports the dysautonomic theory of fibromyalgia<sup>4</sup> including mechanisms of central pain pathway sensibilization.<sup>5</sup> It is clear that there is a lot of road to cover; nonetheless, this paradigm seems to provide a coherent explanation to the sometimes bizarre manifestations of the syndrome. It has been our experience that patients with FM, at least the majority of them, agree with this explanation.

– Integral treatment. The conventional medical outpatient visit that results in the prescription of a drug is not an effective formula for many persons with FM. Information and non-medication treatments must be privileged. This is better achieved in special “clinics”<sup>6</sup> in which the person with FM is integrated to a small group of patients. A

psychologist and a rehabilitated patient can coordinate these groups. In group sessions, the patients with FM are offered information on their illness, cognitive and behavioral therapies, diverse physiotherapeutic disciplines, nutritional counseling, psychological support, etc. The physician is in charge of diagnosis, supervision and drug prescription. It is likely that this type of group therapy is most effective and less costly.

In the discussions that concern the physician-patient relationship in the context of FM, a frequent question is: what kind of specialist is the most adequate to treat these cases? From a historical standpoint rheumatologists have been the ones defining and characterizing the disease. Maybe no other specialist is better trained to separate FM from other rheumatic diseases that have similar clinical characteristics. The differential diagnosis with other rheumatic diseases such as Sjögrens´ syndrome, systemic lupus erythematosus, seronegative spondyloarthropathies, or polymyalgia rheumatica is not always easy. The physician in charge of attending patients with FM must have ample knowledge on internal medicine and must be up to date on the recent advances in the ethyopathogenesis of disease. Of course, one must believe that FM is a distinct nosologic entity and accept the challenge that this represents. Such a physician could be a rheumatologist, neurologist, internist or family physician. On the other hand it must be pointed out that new evidence indicated that FM is a neurological illness, making it urgent to involve the neurologists in the research protocols relating to FM. We live in an age of universal access to information. Information empowers. In the context of health care, many patients demand to be actors and not just spectators. We must invite them to sit at our table and exchange perspectives on their disease. Frontal and open dialogue will surely help to improve the relationship between physicians and patients.

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