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Reluctance and its determinants in managing fibromyalgia patients among Moroccan rheumatologists

Faslı romatologlar arasında fibromiyalji hastalarının yönetiminde isteksizlik ve belirleyicileri

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Abstract

Objective: Fibromyalgia is a complex and disabling chronic pain condition with poorly understood mechanisms and limited treatment efficacy. These uncertainties often lead to skepticism and reluctance among healthcare professionals. This study aimed to assess Moroccan rheumatologists' willingness to manage fibromyalgia patients and to identify influencing factors, with the goal of improving physician-patient relationships and overall care.

Methods: A cross-sectional survey was conducted among rheumatologists affiliated with the Moroccan Society of Rheumatology. Participants completed an electronic questionnaire that included socio-demographic and professional data, willingness to manage fibromyalgia patients, and validated tools assessing frustration (Difficult Doctor-Patient Relationship Questionnaire), illness perception (Brief Illness Perception Questionnaire, BIPQ), personality traits (Big Five Inventory-10), and burnout (abbreviated Maslach Burnout Inventory).

Results: Seventy-one rheumatologists participated. Forty-four (62%) reported reluctance to manage fibromyalgia patients, mainly due to difficult interactions (n=39; 70%) and perceived therapeutic inefficacy (n=31; 56%). High frustration scores were observed in 62 participants (87%). Fibromyalgia was perceived as a severe and impactful condition (mean BIPQ=44.5±16.9). In multivariate analysis, older age was independently associated with lower resistance to care [odds ratio (OR): 1.072; 95% confidence interval (CI): 1.010-1.138; p=0.021], as was the perception that patients were concerned about their illness (OR: 1.274; 95% CI: 1.033-1.571; p=0.024).

Conclusion: Reluctance to manage fibromyalgia patients is frequent among Moroccan rheumatologists, mainly driven by challenging interactions and perceived therapeutic limitations. Targeted training for younger physicians and communication-centered approaches may improve physician-patient relationships and patient outcomes.

Keywords: Fibromyalgia, physician-patient relations, professional burnout, personality traits, surveys and questionnaires

Özet

Amaç: Fibromiyalji, mekanizmaları tam olarak anlaşılamayan ve tedavi etkinliği sınırlı olan, karmaşık ve yeti yitimine yol açan kronik bir ağrı durumudur. Bu belirsizlikler, sağlık çalışanları arasında sıklıkla şüpheciliğe ve isteksizliğe yol açmaktadır. Bu çalışma, Faslı romatologların fibromiyalji hastalarını yönetme konusundaki istekliliklerini değerlendirmeyi, etkileyen faktörleri belirlemeyi ve böylece hekim-hasta ilişkisini ve genel bakım kalitesini iyileştirmeyi amaçlamıştır.

Yöntem: Fas Romatoloji Derneği'ne bağlı romatologlar arasında kesitsel bir anket çalışması yürütülmüştür. Katılımcılar; sosyo-demografik ve profesyonel verileri, fibromiyalji hastalarını yönetme istekliliğini ve şu valide edilmiş araçları içeren elektronik bir anketi doldurmuştur: Zor Hekim-Hasta İlişkisi Ölçeği, Hastalık Algısı Ölçeği (BIPQ), Kişilik Özellikleri Ölçeği ve Tükenmişlik Ölçeği.

Bulgular: Çalışmaya 71 romatolog katılmıştır. Kırk dört katılımcı (%62), temel olarak zor etkileşimler (n=39; %70) ve algılanan terapötik yetersizlik (n=31; %56) nedeniyle fibromiyalji hastalarını yönetmede isteksizlik bildirilmiştir. Katılımcıların 62'sinde (%87) yüksek hayal kırıklığı puanları gözlemlenmiştir. Fibromiyalji, şiddetli ve etkisi yüksek bir durum olarak algılanmıştır (ortalama BIPQ=44.5±16.9). Çok değişkenli analizde, ileri yaşın bakım direncini azalttığı [risk oranı (OR): 1.072; %95 güven aralığı (GA): 1.010-1.138; p=0.021] ve hastaların hastalıkları konusundaki endişe algısının isteklilikle ilişkili olduğu (OR: 1.274; %95 GA: 1.033-1.571; p=0.024) saptanmıştır.

Sonuç: Faslı romatologlar arasında fibromiyalji hastalarını yönetme konusundaki isteksizlik yaygındır ve temel olarak zorlu iletişimler ile terapötik sınırlamalardan kaynaklanmaktadır. Genç hekimlere yönelik hedeflenmiş eğitimler ve iletişim odaklı yaklaşımlar, hekim-hasta ilişkisini ve hasta sonuçlarını iyileştirmeye yardımcı olabilir.

Anahtar Kelimeler: Fibromiyalji, hekim-hasta ilişkileri, mesleki-tükenmişlik, kişilik özellikleri, anketler ve soru formları

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Introduction

Fibromyalgia (FM) is a chronic widespread pain syndrome frequently associated with fatigue, sleep disturbances, cognitive dysfunction, and multiple somatic symptoms. Although it is officially recognized by the World Health Organization and included in the 11th revision of the International Classification of Diseases, FM remains a controversial nosological entity, both in terms of its pathophysiology and its clinical management.[1] The absence of specific biomarkers and the subjective nature of symptoms make the diagnosis essentially clinical, often leading to diagnostic uncertainty and therapeutic delays. This medically unexplained profile may also create tensions in the physician-patient relationship.[2]

Several studies have shown that patients with FM are often perceived as "difficult" by healthcare professionals, due to the chronicity of symptoms, poor response to conventional treatments, and the emotional burden they impose. Such negative perceptions can impair the therapeutic relationship, reduce patient satisfaction, and compromise treatment adherence.[3]

While numerous studies have been conducted in Western and Asian countries, data from North Africa remain scarce. To our knowledge, this study provides the first regional data on physicians' reluctance to manage FM patients. It is also the first to examine healthcare providers' personality traits as potential determinants of reluctance, offering novel insights into the psychological and professional factors influencing FM management.

The objective of this study was to assess Moroccan rheumatologists' reluctance to manage FM patients and identify associated factors through a cross-sectional survey. By generating data from North Africa, this study clarifies the situation on the continent, complements existing evidence from other regions, and supports the development of strategies to strengthen the physician-patient relationship and improve FM care.

Materials and Methods

Study Design and Population

This cross-sectional survey was conducted in April and May 2024 among Moroccan rheumatologists who are members of the Moroccan Society of Rheumatology. The study was approved by the Tangier Hospital-University Ethics Committee (approval date: 06.03.2024, approval number: AC76V/2024). Participation was entirely voluntary, and informed consent was obtained electronically. Specifically, the first question of the online questionnaire asked participants whether they agreed to complete the survey. Only those who answered "yes" were able to proceed to the subsequent questions. Before answering the questionnaire, participants were informed of the study objectives, the estimated time required to complete the questionnaire (5 minutes), and the guarantee of anonymity.

The questionnaire was designed using the Google Forms platform and distributed to 270 rheumatologists via WhatsApp. To optimize participation, six reminders were sent through the same platform during the data collection period. A technical restriction within Google Forms ensured that each participant could submit the questionnaire only once, thereby preventing duplicate responses (Supplementary File 1).

Socio-demographic and Professional Characteristics

The first section of the questionnaire collected information on age, sex, professional status (resident or practicing rheumatologist in the public, private, or academic sector), years of clinical experience, and the number of FM patients seen weekly (<1, 1-5, or >5).

Reluctance to Accept FM Patients

To evaluate willingness to manage FM patients, the following question was asked: "If a known or suspected FM patient wishes to consult you, do you feel reluctant to accept them in your practice?" Respondents who answered "yes" were invited to select one or more reasons from a predefined list: persistent doubts about FM as a valid condition; belief that psychiatrists or pain specialists are more appropriate for these patients; perceived difficulties in interaction or time-consuming consultations; perceived inefficacy of treatments; or other reasons.

Frustration

Physician frustration was assessed using the 10-item Difficult Doctor-Patient Relationship Questionnaire (DDPRQ-10), a validated tool for evaluating frustration with patients suffering from chronic illness. Each item was rated on a 6-point Likert scale (1="not at all" to 6="very much"). A total score ≥30 indicates that the patient is perceived as difficult to manage.[4,5]

Illness Perception

Illness perception was assessed using the physician version of the Brief Illness Perception Questionnaire (BIPQ). This 9-item tool evaluates the cognitive, emotional, and comprehensibility dimensions of illness perception, with each item rated from 0 to 10. Higher scores indicate greater perceived severity. An additional item assessed causal attribution by asking participants to list the top three perceived causes of FM, including biological, psychological, or social factors.[6-10]

Burnout

Burnout was assessed using the abbreviated Maslach Burnout Inventory (aMBI) comprising nine items. This instrument

explores three dimensions: emotional exhaustion (EE; items 1-3), depersonalization (DP; items 4-6), and personal accomplishment (PA; items 7-9). Participants rated the frequency of symptoms on a 7-point Likert scale ranging from 0 ("never") to 6 ("every day"): 0=never, 1=a few times a year, 2=at least once a month, 3=a few times a month, 4=once a week, 5=a few times a week, 6=every day.

Each subscale score was calculated as the sum of its corresponding items. Higher EE/DP scores and lower PA scores indicated greater burnout. For EE and DP, scores of 0-9 indicate no or low burnout, whereas scores of 10-18 indicate moderate or high burnout. For PA, scores of 0-9 indicated moderate to high burnout, while scores of 10-18 indicated no burnout. Participants were classified as experiencing burnout if they scored in the moderate/high range on at least two of the three subscales, in accordance with established definitions.[11]

Personality Traits

Personality traits were assessed using the 10-item Big Five Inventory (BFI-10), which covers five domains: extraversion, agreeableness, conscientiousness, neuroticism, and openness. Each domain was represented by two items, one positively phrased and one negatively phrased, rated on a 5-point Likert scale. The most representative trait from each of the five domains was retained for analysis.[12]

Data Collection

Data were collected using Google Forms. The survey link was distributed via WhatsApp to 270 Moroccan rheumatologists and rheumatology residents affiliated with a national Society of Rheumatology. A brief introductory note explained the objectives of the study.

Statistical Analysis

Survey data were extracted to Microsoft Excel and analyzed using SPSS version 21.0. Descriptive statistics were calculated for all variables. Categorical variables were expressed as frequencies and percentages, while continuous variables were presented as means with standard deviations or as medians with interquartile ranges, depending on their distribution. Binary logistic regression was performed to identify factors associated with reduced reluctance to manage patients with FM. A p-value <0.05 was considered statistically significant

Results

Demographic Data

A total of 71 responses were collected, representing a response rate of 26% (71/270). Women accounted for 80.3% of the participants. The mean age was 38.9±10.8 years. Private sector practitioners represented 31% of respondents. The median number of years in clinical practice was 7.[3-15] Approximately 36.2% of rheumatologists reported seeing between one and five patients with FM per week (Table 1).

Reluctance to Accept Fibromyalgia Patients

In response to the question "If a patient diagnosed with or suspected of having FM wishes to consult you, do you feel reluctant to accept them in your practice?" more than half of physicians (62%) answered "yes." The most frequently reported reasons were perceived difficulty interacting with FM patients (70.9%), the perceived inefficacy of current treatments (57%), and the time-consuming nature of their management during consultations (46%) (Table 2).

Rheumatologists' Frustration

The mean score on the 10-item DDPRQ-10 was 38.1±8.0. Among the participants, 87.3% perceived patients with FM as frustrating and difficult to manage (Table 3).

Illness Perception

FM was perceived as a severe condition, with a mean score of 44.5±16.9 on the 9-item BIPQ. The highest scores were observed for the items assessing emotional impact, perceived consequences, and chronic timeline. In contrast, the lowest scores were reported for symptom experience and perceived treatment control. Moderate scores were noted for perceived understanding of, and concern about, the illness. Regarding causal attributions, psychological factors were most frequently cited as the perceived causes of FM (Table 4).

Table 1. Demographic characteristics of participants

	n=71
Age (a)	38.86±10.75
Gender (b)	
Female	57 (80.3%)
Male	14 (19.7%)
Professional status (b)	
Rheumatology resident	30 (42.3%)
Private practice rheumatologist	22 (31%)
Public sector rheumatologist	12 (16.9%)
University-affiliated rheumatologist	7 (9.9%)
Years of practice (c)	7 [3-15]
Previous experience in managing FM patients (b)	67 (94.4%)
Number of FM patients seen per week (b)	
Fewer than 1 patient/week	39 (56.5%)
Between 1 and 5 patients/week	25 (36.2%)
More than 5 patients/week	5 (7.2%)

Values are expressed as follows: a mean ± standard deviation. b: Percentage, c: Median and interquartile range. FM: Fibromyalgia

Burnout and Personality Traits

Assessment with the aMBI revealed higher scores on the PA subscale (mean: 10.9±4.3), while scores for EE and DP were lower [8.8±5.2 and 3, (1-5) respectively].

Regarding the BFI-10, the highest personality trait scores were observed for conscientiousness (mean: 8.0±1.6), followed by agreeableness (mean: 7.4±1.4) (Table 5).

Factors Associated with Lower Reluctance to Accept Fibromyalgia Patients

In univariate analysis, older age [odds ratio (OR): 1.062; 95% confidence interval (CI): 1.012-1.114; p=0.015], the perception that patients are concerned about their condition (OR: 1.240; 95% CI: 1.040-1.479; p=0.017), and the personality trait agreeableness (OR: 1.557; 95% CI: 1.048-2.312; p=0.028)

Table 2. Reasons for reluctance to manage fibromyalgia patients, n=71

	n (%)
Feels reluctant to accept an FM patient (a, b)	44 (62%)
Contact with FM patients is often difficult (a, b)	39 (70.9%)
Current treatment options for FM are often ineffective (a, b)	31 (56.4%)
FM management consumes a large part of consultation time (a, b)	25 (45.5%)
Persistent doubt about the legitimacy of the FM diagnosis (a, b)	13 (23.6%)
Pain specialists are more suitable to manage these patients (a, b)	11 (20%)
Psychiatrists are more suitable to manage these patients (a, b)	10 (18.2%)
Other (a, b)	6 (10.9%)

Values are presented as numbers (a) and percentages (b). FM: Fibromyalgia

Table 3. Difficult Doctor Patient Relation Questionnaire (DDPRQ), n=71

	Mean (SD)
How much are you looking forward to a fibromyalgia patient's next visit? (r)	4.79 (1.31)
How "frustrating" you find a fibromyalgia patient?	3.49 (1.60)
How manipulative you find a fibromyalgia patient?	2.94 (1.42)
To what extent are you frustrated by fibromyalgia patient's vague complaints?	3.72 (1.38)
How self-distractive is the fibromyalgia patient?	3.06 (1.35)
Do you find yourself secretly hoping a fibromyalgia patient will not return?	3.08 (1.77)
How at ease you feel with fibromyalgia patients? (r)	4.54 (1.10)
How time consuming is caring for a fibromyalgia patient?	4.11 (1.45)
How enthusiastic do you feel about caring for a fibromyalgia patient? (r)	4.65 (1.25)
How difficult is it to communicate with a fibromyalgia patient?	3.75 (1.47)

DDPRQ Questions ranked 0-6 (r-reverse scale). Values are presented as mean ± standard deviation (SD)

Table 4. Physicians' illness perceptions and causal attribution. Illness perception items (range 0-10), n=71

	Mean (SD)
Consequences: How much does fibromyalgia affect the patient's life? (a)	**7.08 (2.87)**
Timeline: How long do you think fibromyalgia will continue? (a)	**6.87 (2.73)**
Personal control (r): In general, how much control do you think patients have over fibromyalgia in general? (a)	3.96 (2.85)
Treatment control (r): How much do you think general treatment can help fibromyalgia? (a)	6.55 (2.94)
Identity: How much do patients experience symptoms from fibromyalgia? (a)	**2.75 (2.54)**
Concern: In general, how much are patients concerned about their illness? (a)	5.49 (3.05)
Understanding (r): In general, how much do you feel patients understand about their illness? (a)	4.46 (2.82)
Emotional response: In general, how much does fibromyalgia affect patients emotionally? (a) (e.g., anger, fear, confusion depression)	**7.32 (2.94)**
Causal attribution items (b)	
Biologic factors	**59.2%**
Sociologic factors	**38%**
Psychologic factors	**87.3%**

Values are presented as follows: a: Mean ± standard deviation, b: Percentage, r: Stands for reverse items, SD: Standard deviation

were significantly associated with lower reluctance to accept FM patients. In the multivariate analysis, only age (OR: 1.072; 95% CI: 1.010-1.138; p=0.021) and the perception that patients were preoccupied with their illness (OR: 1.274; 95% CI: 1.033-1.571; p=0.024) remained significantly associated with reduced resistance to accepting these patients (Table 6).

Discussion

This study provides new insights into the perceptions and attitudes of rheumatologists toward patients with FM, a population often regarded as challenging to manage. Our findings reveal high levels of frustration and a notable reluctance to accept FM patients in clinical practice, reflecting a physician-patient relationship characterized by uncertainty and emotional burden.

More than 60% of surveyed rheumatologists reported reluctance to treat FM patients, citing difficult interactions (70.9%), limited treatment efficacy (57%), and time-consuming consultations (46%). These findings are consistent with those reported by Homma et al.[13] in Japan, where only 44.2% of rheumatologists were willing to accept new FM patients. In that study, reluctance was mainly attributed to difficulties in controlling symptoms rather than to negative stereotypes toward patients themselves. Symptom management challenges were also identified as the primary source of physician frustration. In our sample, the high mean DDPRQ-10 score (38.1±8.0) further illustrates this resistance, with over 87% of participants perceiving FM patients as "difficult." Similar conclusions were drawn by Walker et al.[14], who reported that somatization, loss of control, and psychiatric comorbidities were significant contributors to physician frustration. Such widespread reluctance, across different contexts, is likely to have negative repercussions for patient care by undermining the therapeutic alliance.

Table 5. Burnout according to the aMBI and personality traits of participants according to the BFI-10 a, n=71

Maslach Burnout Inventory (a BMI)	
Emotional exhaustion (EE) a	8.77±5.19
Depersonalization (DP) b	3 [1-5]
Personal accomplishment (PA) a	**10.86±4.34**
BFI-10 a	
Extraversion	6.59±2.01
Agreeableness	**7.42±1.37**
Conscientiousness	**7.96±1.62**
Neuroticism	5.86±2.17
Openness to experience	6.68±1.50

Values are presented as follows: a: Mean ± standard deviation, b: Median and interquartile range, BFI-10: Big Five Inventory-10

Table 6. Univariate and multivariate analysis of factors associated with lower reluctance to manage FM patients

Variable	Univariate OR (95% CI)	p-value	Multivariate OR (95% CI)	p-value (multivariate)
Age	**1.062 (1.012-1.114)**	**0.015**	**1.072 (1.010-1.138)**	**0.021**
Gender	1.131 (0.335-3.818)	0.842	-	-
Professional status	1.096 (0.678-1.773)	0.708	-	-
Perception that patients are concerned about their condition	**1.240 (1.040-1.479)**	**0.017**	**1.274 (1.033-1.571)**	**0.024**
Emotional exhaustion (EE)	1.018 (0.928-1.118)	0.702	-	-
Depersonalization (DP)	0.963 (0.851-1.089)	0.546	-	-
Personal accomplishment (PA)	1.019 (0.911-1.139)	0.742	-	-
Agreeableness (BFI-10)	**1.557 (1.048-2.312)**	**0.028**	**1.168 (0.745-1.832)**	**0.498**
Extraversion	1.229 (0.953-1.587)	0.113	-	-
Conscientiousness	0.994 (0.733-1.347)	0.967	-	-
Neuroticism	1.018 (0.815-1.272)	0.874	-	-
Openness to experience	1.250 (0.896-1.744)	0.189	-	-
Causal attribution: Biological factors	0.600 (0.222-1.625)	0.315	-	-
Causal attribution: Psychological factors	3.905 (0.887-17.194)	0.072	-	-
Causal attribution: Social factors	3.905 (0.887-17.194)	0.072	-	-

BFI-10: Big Five Inventory-10, CI: Confidence interval, FM: Fibromyalgia, OR: Odds ratio

The perception of FM among participating rheumatologists reflects a complex and partly contradictory view. FM was generally recognized as a severe and chronic condition, as indicated by the high overall BIPQ score (44.5±16.9). The highest item scores were reported for emotional impact, perceived consequences, and chronic timeline, suggesting that physicians acknowledge the persistent and disabling nature of the disease. In contrast, lower scores were observed for symptom recognition and perceived treatment control, indicating uncertainty regarding the clinical specificity of FM and limited confidence in therapeutic efficacy. Moderate scores for patients' understanding of the illness and for concern about the disease further highlight a perception of FM as poorly understood and emotionally complex. Collectively, these findings suggest that FM is perceived as a disabling condition with ill-defined clinical boundaries, potentially impairing care delivery and undermining trust in the physician-patient interaction.

Regarding causal attributions, 87.3% of surveyed rheumatologists identified psychological factors as the primary cause of FM, followed by biological (59.2%) and sociological (38%) factors. This suggests that physicians tend to conceptualize FM within a biopsychosocial framework. In Uclés-Juárez et al.'s[3] Spanish study, 60% of general practitioners and 66% of internists considered FM a form of somatization, whereas rheumatologists adopted a more biomedical and nuanced perspective. Similarly, in Arshad and Kong's[15] study of Southeast Asian rheumatologists, 92.5% acknowledged FM as a clinical entity, but only 3% considered it purely medical in origin, with most (87%) favoring a psychomedical explanation.[3-15]

In our study, burnout levels among rheumatologists were low according to the aMBI, and no significant association was found between burnout and reluctance to manage FM patients. This contrasts with findings from other studies. For instance, the EPIFFAC study in Spain reported that 25% of family physicians exhibited high levels of burnout, characterized by EE, DP, and reduced PA, and perceived FM patients as burdensome, with more negative impressions associated with higher burnout scores.[16] Thus, while general burnout may be infrequent in our sample, emotional fatigue specifically triggered by FM consultations cannot be excluded.

Multivariate analysis identified two factors independently associated with lower resistance to managing FM patients: physician age and the perception that patients are concerned about their condition. Although certain personality traits, particularly agreeableness, were associated in univariate analysis, none remained significant in the multivariate model, suggesting that personality plays only a secondary role. These findings are consistent with those of Mostafapour et al.[17], who noted that while personality traits may influence the quality of the physician-patient relationship, personal engagement remains one of its strongest determinants.

Study Limitations

This study has several strengths, including its targeted approach, the use of validated assessment tools, and the exploration of a largely understudied context. To our knowledge, it is the first study to examine the association between reluctance to manage FM patients and physicians' personality traits. Nonetheless, some methodological limitations should be acknowledged, particularly the modest response rate (26%), which resulted in a restricted sample size, and the reliance on self-reported data.

Conclusion

Overall, this study reveals a predominantly negative perception of FM among rheumatologists, marked by significant reluctance to provide care, elevated levels of frustration, and an unclear conceptualization of the disease. These factors represent major barriers to establishing a high-quality physician-patient relationship. Our findings highlight the urgent need for continuing medical education focused on chronic pain management, therapeutic communication, and clinical recognition of functional symptoms. Moreover, promoting a biopsychosocial approach to FM care appears essential to rebuilding trust and strengthening the therapeutic alliance.

In-depth qualitative studies are warranted to better understand the underlying factors driving physicians' reluctance to treat FM patients. Such investigations may substantially improve the quality of care, not only for individuals with FM but also for those with other unexplained chronic pain syndromes.

Ethics

Ethics Committee Approval: The study was approved by the Tangier Hospital-University Ethics Committee (approval date: 06.03.2024, approval number: AC76V/2024).

Informed Consent: Participation was entirely voluntary, and informed consent was obtained electronically.

Footnotes

Authorship Contributions

Concept: R.B., F.Z.T., N.T., F.E.A., Design: R.B., F.Z.T., Data Collection and Processing: R.B., F.Z.T., Analysis or Interpretation: R.B., F.Z.T., A.A., Literature Search: R.B., Writing: R.B., F.Z.T., N.T., A.A., F.E.A.

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Supplementary File 1: https://d2v96fxpocvxx.cloudfront.net/2c83d69a-dc5a-476c-9385-2d943ca48693/content-images/e5110db9-1ab3-42bc-a520-61cb5ca3010d.pdf

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