Canadian Headache Society
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CHS Position Statement

Not Just Needles: **Providing Ethical and Comprehensive Migraine Care**

Context and Purpose

This statement aims to articulate the principles of responsible care in this evolving treatment landscape—whether delivered by primary care physicians, pain specialists, neurologists, or nurse practitioners. Headache care is not defined by procedures alone, and patients deserve providers who commit to holistic management, regardless of the success or failure of a specific intervention.

With recent revisions to the Canadian product monograph for onabotulinumtoxinA (Botox®), nurse practitioners (NPs) are now authorized to prescribe this treatment for chronic migraine. Alongside the increasing availability of cephalic nerve blocks, this change represents an important and necessary step toward improving access to evidence-based care for individuals living with disabling migraine. However, as more providers from diverse disciplines begin to offer procedural interventions—including Botox® and nerve blocks—it is essential to emphasize that migraine care must remain comprehensive, evidence-informed, and ethically grounded.

Migraine Management Is Not Just About Needles

Procedural therapies such as onabotulinumtoxinA and cephalic nerve blocks are valuable components of chronic migraine care. However, focusing solely on procedures risks oversimplifying the complexity of migraine as a neurologic disorder.

While cranial nerve blocks are commonly offered in some settings for migraine prevention, it is important to recognize the paucity of robust evidence supporting their routine use for this indication. Evidence-based practice must remain the foundation of ethical care, particularly when preventive treatments with stronger clinical trial data—such as calcitonin gene-related peptide (CGRP) monoclonal antibodies or onabotulinumtoxinA—are available. Nerve blocks may have a role in specific clinical scenarios, such as refractory cases, contraindications to systemic medications, or during pregnancy. In most cases, they should be considered as adjunct or ancillary interventions in addition to established evidence-based practices. However, they should not be positioned as first-line or monotherapeutic preventive options without careful consideration of the individual patient's context and the current evidence base.

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Migraine is a fluctuating, multifactorial disease influenced by biological, psychological, and environmental factors. Effective treatment involves far more than injections:

- **Diagnosis and Education**: Providers must confirm accurate diagnosis, educate patients about the nature of their condition, and set realistic expectations for treatment.
- **Lifestyle and Behavioral Strategies**: Sleep hygiene, dietary triggers, hydration, and stress management all play pivotal roles in migraine outcomes.
- **Acute and Preventive Pharmacotherapy**: A comprehensive plan includes rescue treatments, appropriate preventives, and thoughtful monitoring of efficacy and safety.
- **Monitoring, Follow-up, and Adjustment**: Treatment response must be assessed regularly, and strategies adjusted to reflect evolving patient needs.

Patients who undergo procedural therapy but do not improve deserve follow-up care and an expanded plan—not discharge or dismissal. Comprehensive care is the moral and professional foundation upon which procedural success must be built.

Ethics and Equity in Headache Practice
Migraine is a serious neurological disease that warrants multidisciplinary care. Ethical practice must ensure that:

- **Care is guided by patient outcomes, not provider revenue**. A disturbing trend is emerging wherein providers offer only the profitable aspects of care—such as Botox® injections or nerve blocks—while failing to follow through when these do not yield results. This is a breach of duty to the patient.
- **Providers do not "cherry-pick" patients based on complexity, comorbidity, likelihood of procedural success, or financial gain**. Headache medicine, like any subspecialty, must embrace the full spectrum of disease severity and complexity.
- **Comprehensive migraine care** includes a thorough evaluation to rule out secondary causes of headache, ensuring that serious underlying conditions are not overlooked. Ethical practice requires clinicians to approach diagnosis thoughtfully, and to offer both acute and preventive treatment options tailored to the individual—rather than defaulting to a one-size-fits-all procedural model.
- **No patient is abandoned when a particular treatment does not work**. Instead, a plan should be made for reassessment, referral, or a layered treatment strategy that includes newer or alternative preventive options.

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- **Collaborative care models are embraced**, especially in regions with limited neurologist access. Nurse practitioners, family doctors, pharmacists, and headache specialists all have roles to play in shared care models that support patient-centered treatment plans.

In some clinical settings, it may be appropriate for physicians to delegate specific procedural tasks—such as cephalic nerve blocks or onabotulinumtoxinA injections—to providers whose practice focuses primarily on interventions. When done within a coordinated, team-based model, this delegation can enhance clinic efficiency, improve patient flow, and ensure timely access for new consults without compromising care quality.

However, this model must be grounded in a comprehensive care plan led by a provider committed to the full scope of headache management. It is ethically problematic when procedures are offered in isolation by providers who are not engaged in diagnosis, preventive planning, follow-up, or longitudinal support. Procedural care should complement—not substitute—a robust, patient-centered treatment strategy. Pursuing only the more lucrative aspects of headache medicine, while neglecting the rest of the clinical picture, ultimately undermines patient outcomes and the integrity of the field.

The Moral Imperative: Comprehensive Care Before Procedural Preference
Headache medicine is not merely a technical specialty. It is a relationship-based field rooted in the biopsychosocial model. Providers who pursue procedural care must be equally committed to:

- **Optimizing preventive adherence** before declaring treatment failure.
- **Discussing mental health comorbidities**, sleep disorders, trauma history, and lifestyle contributors.
- **Engaging with patients longitudinally**, rather than treating them as episodic procedures.

The privilege to administer interventions like nerve blocks or Botox® should come with the responsibility to provide—or ensure access to—broad, holistic care. Anything less risks undermining the integrity of the field, short-changing patients, and creating two-tiered care models that reward profit over outcome.

Conclusion
Expanding the ability to prescribe and administer procedural therapies such as onabotulinumtoxinA and cephalic nerve blocks is a welcome development in headache care access. However, with this privilege comes the obligation to ensure that treatment is

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not reduced to a series of injections. Regardless of specialty or professional designation, providers must commit to comprehensive, ethical, and patient-centered care that reflects the true nature of migraine as a complex neurological condition. In headache medicine, we are not just technicians—we are stewards of our patients' long-term health and quality of life.

The Canadian Headache Society welcomes all healthcare providers who are committed to the care of people living with migraine. For those seeking to add injection or procedural interventions for headache to their repertoire, CHS encourages further learning and offers educational resources and opportunities to help develop and deepen expertise in headache care.