Communication Issues in Migraine Diagnosis

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ABSTRACT: ***Objectives:*** To examine the importance of good communication when informing the patient of the diagnosis of migraine; to review the essentials of successful communication between physician and patient on the aspect of diagnosis; to survey learning resources for physicians on communicating information to patients. ***Methods:*** This paper is based on observations made by the author of the successful interactions of numerous international "headache experts" with their patients, on a review of the medical education literature pertaining to the teaching of communication skills, and on 30 years of not always successful communication with patients. ***Results:*** Communicating the diagnosis of migraine is an opportunity to educate and reassure the patient, to lay the foundation for rational treatment and to help establish the successful doctor-patient relationship which is essential for effective management. No matter how accurate the diagnosis, failure to communicate it effectively to the patient (and often to significant others) may impair interactions with the patient and compromise therapy. Effective communication of a diagnosis requires clarity, relevance to the patient, a positive attitude, and reinforcement through repetition, questioning and dialogue. In terms of using the diagnosis to lay a foundation for therapy, it is useful to explain the symptoms as transient physical dysfunction of normal tissues, to indicate that there are multiple mechanisms underlying the dysfunction of which only some may presently be susceptible to treatment and to stress the relevance of emotions as factors which may powerfully affect, for better or worse, the underlying disturbed physiology of migraine. Into this model can be "plugged" all the relevant therapies for migraine. This is the ideal, but every day experience in the headache consultant's office suggest that in both primary care and specialist practice, it is infrequently attained. There are scant resources other than example for physicians to learn communication of headache diagnosis specifically but there are numerous print and web resources available to physicians who wish to learn and/or teach the generic principles of effective communication, and these principles require little or no modification to be applied to the headache patient and the headache doctor.

RÉSUMÉ: Problèmes de communication dans le diagnostic de la migraine. ***Objectifs:*** Examiner l'importance d'une bonne communication au moment où on informe le patient du diagnostic de migraine; revoir l'essentiel d'une communication efficace entre le médecin et le patient au sujet du diagnostic; répertorier les ressources d'apprentissage pour les médecins sur la communication d'informations aux patients. ***Méthodes:*** Cet article est basé sur des observations faites par l'auteur sur les interactions réussies de nombreux experts internationaux de la céphalée avec leurs patients, sur une revue de la littérature éducative médicale concernant l'enseignement des aptitudes à communiquer et sur 30 ans de communication pas toujours réussie avec des patients ***Résultats:*** La communication d'un diagnostic de migraine est une occasion d'éduquer et de rassurer le patient, d'établir la base d'un traitement rationnel et d'aider à établir une bonne relation médecin-patient essentielle à un traitement efficace. Quelle que soit l'exactitude du diagnostic, si le diagnostic n'est pas communiqué adéquatement au patient (et souvent à ses proches), l'interaction avec le patient et le traitement peuvent être compromis. Une communication efficace du diagnostic est basée sur une information claire et pertinente pour le patient, une attitude positive et un renforcement par la répétition, l'interrogation et le dialogue. Pour utiliser le diagnostic comme fondement de la thérapie, il est utile d'expliquer les symptômes comme étant une dysfonction physique transitoire de tissus normaux, d'indiquer qu'il existe de nombreux mécanismes sous-jacents à cette dysfonction dont seulement quelques uns peuvent être sensibles au traitement et de souligner la part des émotions comme facteurs qui peuvent affecter énormément, pour le meilleur ou pour le pire, la physiologie perturbée sous-jacente à la migraine. On peut inclure dans ce modèle tous les traitements pertinents. C'est le modèle idéal, mais l'expérience quotidienne dans le bureau du médecin qui traite des patients présentant de la céphalée suggère que, tant en pratique générale qu'en spécialité, il est rarement atteint. Les ressources sont rares, à part l'exemple, pour l'apprentissage par les médecins de la communication d'un diagnostic de céphalée, mais il existe plusieurs ressources dans la littérature ou sur Internet pour les médecins qui désirent apprendre et/ou enseigner les principes de base de la communication efficace, et ces principes demandent peu ou pas de modifications pour être applicables au patient souffrant de céphalée et au médecin qui le traite.

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The functions of diagnosis

As physicians, there is a strong intellectual imperative to make a diagnosis, and considerable personal satisfaction results when we succeed. This is especially so with headache because of the multiplicity of causes for this symptom, the usual impossibility of making a diagnosis of a headache by the now

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prevalent method of filling out imaging requests and laboratory requisitions, and the absolute need for history-taking and physical examination skills and clinical judgement. Walter Alvarez, an eminent mid-twentieth century physician, epitomized this in his remark, "If I wanted to see what a consultant is made of, I'd refer him a patient with a headache".[1]

But diagnosis serves other and more important functions. A diagnosis, confidently given and carefully explained, tells the patient what is wrong. Assuming that diagnosis to be migraine, the patient usually finds it to be reassuring. The spectre of brain tumor or other dread disease is dispelled. The diagnosis of migraine opens the door to educating the patient about what migraine is, the dysfunction that underlies it, what the causes of that dysfunction may be, and how those causes may be addressed therapeutically. An accurate diagnosis effectively communicated is the essential substrate of migraine management. This has become especially important in the last decade with the advent of new, highly effective agents, the triptans, that are specific for migraine and largely useless for other types of headaches.[2] Not least important, the manner in which the diagnosis is presented, and whether or not it is accepted by the patient, become powerful determinants of the success or failure of the doctor-patient relationship and, in turn, of the management of the patient's migraine. No matter how astute the physician, and no matter how accurate the diagnosis, failure to communicate that diagnosis effectively can result in a troubled patient, an insecure foundation for therapy, and unhappy encounters. A Canadian survey of migraine sufferers[3] found that 45% of them were no longer seeing physicians; about half of these "lapsed consulters" dropped out because they had communication difficulties with their doctors.

Communicating the migraine diagnosis

The importance of communicating the diagnosis has been indicated in the Canadian Headache Society's guidelines for the management of migraine in clinical practice.[4,5] These guidelines emphasize confidence in the diagnosis, clarity of presentation, and taking the opportunity to use communicating the diagnosis as a springboard for educating the patient about the basis of migraine and for explaining the rationale of the treatment plan.

Communicating a diagnosis is no different from communicating any other information; the same principles apply:

- clarity
- relevance
- sensitivity
- reinforcement

Clarity is essential; people will not accept what they cannot understand. Physicians are highly specialized professionals with highly specialized vocabularies, who therefore may have difficulty, at times, speaking plain English. Sometimes the lack of clarity is not completely involuntary – Voltaire, when asked why philosophers habitually quoted Aristotle in Greek, replied that it is prudent to talk about what one does not entirely understand in a language in which one is unlikely to be entirely understood.[6] It may be tricky, however, meeting the need for clarity without giving patients the (not always mistaken) impression that they are being talked down to.

Relevance should not be difficult to achieve when communicating a diagnosis; who could be more interested in the physician's message than the patient with the symptoms? Yet it is not unusual to see a patient seemingly inattentive, often because the physician has not prefaced the explanation of the diagnosis with an attention-grabbing phrase like, "Now I'm going to tell you what's wrong", or "Here's why you have headaches". The three rules of teaching apply to the communication of a diagnosis: "Tell them what you're going to say; then say it; then tell them what you said".

Sensitivity implies communicating in terms that will not arouse negative emotions that can cloud the patient's understanding of the issues. For example, expressions like, "The bodily changes produced by the stress that you're under are fueling your migraine" are probably preferable, in terms of communication and relationships, to "You're neurotic".

Reinforcement of the diagnostic message, so that it will be retained by the patient, can be optimized by repeating it, as in "This part is so important that I'll say it again"; and by inviting questions, as in "I've been telling you quite a bit; is there anything you'd like clarification about?".

The diagnosis as a foundation for therapy

We now understand enough about the pathophysiology of migraine that we can, in presenting the diagnosis to the patient, explain the symptoms in terms of dysfunction of tissues such as blood vessels in the head, the nerves that influence those vessels, and the brain which exercises ultimate control of the nerves. In so doing we sketch a system for the patient with points in it that can be changed by things the patient can do (e.g. "leading a more regulated life style is less likely to destabilize your excitable cerebral cortex, and hopefully can reduce your migraine attacks") and by things that the physician can do (e.g. "I'll give you a triptan that you can take early in the course of an attack to constrict the swollen blood vessels that are contributing to the headache, and ease the pain"). Physical explanations such as these are generally acceptable to patients, are generally understood by them, and serve as a framework which can make rational the various treatments which are prescribed, thus improving compliance.[7]

It is important, when explaining the diagnosis in terms such as these, to avoid some not-so-obvious pitfalls. Patients should not be made to feel that they are helpless automatons ruled by a disturbed physiology that is beyond their control. A physical explanation should incorporate the concept that thoughts, attitudes and feelings exert strong influences over physical function, and that to the extent that patients can exercise some control (or at least peacefully coexist with) these so-called "psychological" factors, they can mitigate some of the bodily changes that generate migraine. This is the concept of "locus of control". Patients with an internal locus of control ("these are my headaches – tell me what I can do to help them") are much more likely to respond well to migraine therapy than those with an external locus of control ("here I am – fix me").

The physical explanation of migraine should not be presented as "cut and dried", but rather the physician should incorporate some leeway that recognizes the very real gaps in our knowledge of migraine and the differences of opinion that exist among (any

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set of) experts. For example, it is probably a mistake to explain the universe of migraine on the monolithic basis of "serotonin deficiency". A patient who subsequently fails a trial of a serotonin agonist such as a triptan to treat acute attacks, and a course of a serotonin $5HT_2$ antagonist as prophylaxis may lose faith first in the explanation, then in the diagnosis, and finally in the physician. It is better to say something along the lines of, "Many people have their migraine on the basis of serotonin malfunction, others seem to have theirs because of altered dopamine function, and still others have chemical problems that we haven't yet sorted out – but since serotonin is the common one, let's go after that". Point out that experts disagree about everything – it is a fact of life, and that inevitably they will see alternative explanations of their symptoms in books, on television and on the internet; tell them that while the pressures of your practice will not permit you the time to discuss all these variations of expert opinion with them, if they find themselves with serious concerns about these that cannot be resolved through interactions with reputable lay agencies such as ACHE (the American Council for Headache Education) or the JAMA Migraine Information Center at www.ama-assn.org/special/migraine/support.htm, you can schedule a brief appointment with them for further education and counseling.

It is prudent also to indicate that even when we know the chemical problem, we aren't always able to correct it – or more precisely, we don't yet have an invariably effective way of normalizing it. If a patient is going to be surprised, better it be by an excellent result rather than by a failure.

Extending the model

The physical model of communicating the migraine diagnosis can be extended to explaining other types of headaches including those seen, not infrequently, in association with migraine. An example is medication-induced headaches. Some patients who have had this diagnosis explained to them by their physicians have come away with the idea that they have been diagnosed as weak-willed pill-popping neurotics who are now thoroughly addicted and who may, with a lot of effort from specialists, be unhooked from their habit but probably not from their folly. While an explanation couched in these terms has the virtue of clarity, it lacks sensitivity; it likely will be considered by the patients to be irrelevant to them, and thus (fortunately) cannot be reinforced. A more constructive communication of this diagnosis could focus on the role of repeated administration of medication in altering the activity of receptors in the brain and on blood vessels, and on the propensity of these altered receptors to themselves generate headache. A useful addendum to this explanation is to note that while prolonged abstinence from medication frequently allows these receptors to normalize, with regaining of more normal pain control, occasionally it does not. This sets the stage for attempts to withdraw medication while allowing for the contingency that successful abstinence may not remove the chronic daily headache. Importantly, a diagnosis communicated in the physiologic terms is not pejorative, leaves the patient's self-esteem intact, allows for a better doctor-patient relationship, and lays the groundwork for therapy.

Conclusion

Communicating the diagnosis is just as important as making it. Miscommunication misinforms the patient, fails to lay a groundwork for therapy, and imperils the doctor-patient relationship – all occurrences which, from day to day observation from the vantage point of a specialized headache practice, are not infrequent and which account, at least in part, for failures of therapy. Successful communication is a clinical skill that can be taught and learned. Protocols for this are available for medical students,[8,9] family physicians,[10] and specialists,[11] and there are now sophisticated techniques for assessing the effectiveness of this teaching and learning[12] at all levels of medical education. Our ability to diagnose and treat migraine has improved greatly in the past decade, but to transmit these benefits to our patients we need to ensure that we communicate effectively with them.

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