



HEADACHE MANAGEMENT

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The benefits and pitfalls of physician-patient communication:

An interview with Dawn Marcus, MD

Dawn A. Marcus, MD is Associate Professor at the University of Pittsburgh School of Medicine and a neurologist and coordinator of headache research at the Pain Evaluation and Treatment Institute, Pittsburgh, PA. Dr. Marcus speaks and publishes extensively on headache. We spoke with her recently about her interest in improving physician-patient communication.

CHM: How did you become interested in the issue of doctor-patient communication?

DM: At the pain clinic where I work, we used to conduct an intensive pain rehabilitation program where patients would come in for three weeks and be involved in a variety of therapies. It was run by the physician in charge of the group. One of the activities involved role playing by both physicians and patients. We would take turns playing a physician or playing the pain patient. It was an opportunity for the physician to show patients in the group how their behaviors and their modes of communication could be perceived negatively by the physician. It actually turned out to be a very popular activity for patients; it gave them a way to release some of their hostility about doctors not listening to them. They would get to play the worst sort of doctor — the one who would run in and out of the examining room, not listen to them and not look at their charts. It was a way to begin a serious conversation about these issues, and the ultimate result was to help patients improve their own communication skills.

CHM: What did you learn personally from the course?

DM: It helped to show me how a lot of the behaviors that we have as physicians are perceived negatively by our patients. For example, I learned how aloof we can appear when not conveying information to our patients. Unfortunately, in medical school, students aren't taught how to communicate with patients, how to talk to them

on their level so that they'll understand what's going on. Instead, we were instructed about how to talk to other physicians and I'm afraid we often use the same techniques when we speak to patients. The result is the patient may not understand or may misinterpret what we tell them.

Physicians and patients tend to blame each other for communication problems. The physician says, "Well, that patient is just unclear about what's going on." Or, "She just rambles on forever," rather than saying, "What can I do to improve the situation?" I think patients do the same thing. "The doctor comes in, he just goes 'Uhh, uhuh,' and runs out the door; he doesn't talk to me."

Even if you believe you're being very clear in your communication, what the patient hears from you is often very different from what you're saying. It's amazing how medical information can be misperceived. Patients often don't hear anything we tell them because they're anxious, upset or worried. This was really driven home to me during an episode I witnessed as a student. The surgical team minus the attending physician went in to see a patient prior to surgery. The chief resident on our team went through the long list of things that could go wrong during surgery, including some rather hideous potential complications. After the patient understood all the things that could go wrong, he signed the consent for surgery. As we were leaving the room, the attending physician came in and asked the resident, "Did you get the consent?" The resident said, "Yes, I did." The doctor then asked the patient, "I understand that my colleague just talked to you about the possible complications of the surgery." At which point the patient said, "What? What do you mean there could be complications? No one ever told me anything could go wrong." So the attending physician turned around and angrily chastised the chief resident for not having said anything to the patient. Meanwhile, we're all standing there saying, "No really, he went through the whole list." There was a good lesson here: because of the stress of the situation, the patient was listening but not hearing. Unfortunately, we just don't have the training to perceive cues from the patients that indicate they're understanding or even listening to anything we're even telling them.

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CHM: I understand that doctor-patient communication is particularly important in an initial workup for headache.

DM: The problem with headache is that there's no test to do to identify what is causing the headache and what the best therapy is likely to be. The testing and physical examination are done to eliminate serious organic causes of the headache. Once it is determined that the headache is not caused by something serious, like a brain tumor or infection, we rely entirely on what the patient tells us. However, it isn't easy to get accurate information about a patient's headaches. If, for example, people have several different types of headaches, they'll often blend the characteristics of all of their different headaches together, so the doctor ends up with a very odd mixture of symptoms that don't really fit into any particular diagnostic category. This makes it impossible to figure out what's really wrong with the patient, which means you can't come up with an effective treatment strategy. Physicians are not taught to ask, "How many types of headaches do you have?" and then to say "Let's talk about headache number one first and then we'll talk about the other headaches later."

CHM: Do physicians who treat headache receive training in how to elicit accurate information from the patients during the workup?

DM: Not really, and it's interesting, because in medical school they tell you not to ask people pointed questions to get yes or no answers, but to provide open-ended questions and allow them to fill in the details. The problem is that it is very difficult for headache patients to describe accurately what is going on. As a result, physicians get annoyed, because what they want to really find out is, "Do you have photophobia, phonophobia, or nausea?" and other specific symptoms that can lead to a diagnosis. So the patient doesn't know what information to give and the doctor doesn't get it. As the years go on, physicians realize that it takes forever to get those open-ended histories, so they start to ask very pointed questions. For example, they will ask, "Are you sensitive to light?" And, if the patient says "no," they will ask another question. If the patient says "yes," the physician responds with an interested look and will write something in the chart. Eventually patients learn that "yes" answers are positively reinforced, so they think, "I guess that's what I'd better say." So, unfortunately, we train patients to think that yes answers will result in the physician's attention and care. This is in contrast to children, who are reluctant to admit having symptoms like sensitivity to noises and lights, or vomiting.

CHM: Can you give a specific example of this sort of miscommunication?

Instead of asking direct questions, like “Do you have sensitivity to light or sound?” I ask a behavior-oriented question such as “What do you do when you have a headache?”



DM: We had a headache patient who said she had a terrible sensitivity to noises and lights with her headaches, and got really sick to her stomach. So I asked her, “What do you do when you have a headache?” She was a daycare worker and she would continue to work at the daycare center with no apparent difficulty during her headache. Now, those places are so bright and noisy it seemed somewhat incredible, if she were really photophobic and phonophobic, that she would just stay at work. Maybe she’s just one of these people who’s so devoted to keeping on the job that she’ll suffer through her head pain. So I asked, “What if you have a headache at home? If you were home watching television and you had a headache, would you turn it off?” She said, “Oh no, I’d watch television and probably eat a snack.” It’s safe to conclude that she is probably not photophobic, phonophobic, or nauseated. Time and time again we have people come into the office saying, “I’m having a terrible migraine today.” They’re sitting with the bright fluorescent lights on in the room and talking on their cell phones. So, instead of asking direct questions, like “Do you have sensitivity to light or sound?,” I ask a behavior-oriented question, such as “What do you do when you have a headache?” I do the same with children: “Do you turn off the computer and videogame? Do you turn down the radio and close the blinds? Do you go to bed? Are you able to keep up with your regular activities?” Then, if the patient is really photophobic or phonophobic, the response would be, “Oh my gosh, of course not. I have to go lie down and turn the lights off.” I’ve found that this is often a better way to elicit accurate responses than giving a simple check-off list. Unless you’re a completely uneducated patient, it’s pretty clear that when your doctor gives you a list that says: “Check if you have any of these,” and you indicate “No,” then you probably don’t have a condition your doctor is willing to treat. Often, these check-off lists actually encourage you to start checking off items in order to obtain the minimum score for treatment. An indirect approach can actually achieve more specific and accurate information.

CHM: There’s another side to this coin, and I’ve heard this from a number of headache specialists who find that headache patients sometimes have a very poor awareness

of how often they have a headache and how they treat it. They’re unaware, for example, that their medicine cabinets are filled with a shopping bag of various analgesics and they’re taking an awful lot of them.

DM: That’s definitely true and that is why headache diaries are so invaluable. If you give pain diaries to people with chronic back pain, they won’t use them; they think it’s crazy. But if you give a diary to a headache patient, they come back excited and they say, “Oh, I didn’t realize how often I had headaches or how often I was using the medications.” For some reason, headache patients are often totally unaware of their headache patterns and the extent of medication use. Using the diaries becomes very educational for them, and they can be very instructive for their physician, too, assuming the doctor will take time to actually open the diary and look at it.

CHM: Does the diary also give the patient a sense that he or she is participating in his own care?

DM: Yes, and that’s another good reason for the physician to open and read the diary. Unfortunately, what happens too often is that the patient brings it back very excited about what she’s learned and hands the diary to the physician, who just takes it and sticks it in the back of the chart and then starts asking questions. But if the physician opens the diary and spends even one minute looking through it, I think that helps convince the patient that her physician is interested in what’s going on, taking what the patient says seriously, and considers patient input to be very important.

CHM: Have you ever participated in programs for training physicians about how to communicate better with their patients?

DM: We put together an industry-sponsored program that has proved very popular among physicians, who are beginning to recognize that they have communication problems and have a genuine desire to improve their communication skills.

CHM: What do you think is the single biggest mistake physicians make when talking to their patients?

DM: I think the biggest problem is that physicians don't want to be asked questions they can't answer. So, if they can quickly get the information they need and bolt out the door, they're saved the potential embarrassment of saying, "I don't really know," or "I'll have to go look that up." But I think patients are not upset if their doctor says, "I don't know, but I'll look it up." Especially with young doctors, there's a fear that your patient is thinking, "I can't believe you don't know that." I think there's also a concern that if you start communicating with your patients more it's going to be really time consuming. In fact the conversation is quicker if you're actually having a good exchange of information. When I was a resident, my chairman taught me a valuable lesson about communication with patients. He said that when you see patients the key things you have to do are make them get undressed and, when you come into the room, sit down in a chair. Both of those steps give the patient a sense that, "I'm really interested in you." Most of us, when we're in a hurry (as we often are), dash into that examining room, coming in with a posture that says, "We need to be really speedy; you've got two minutes, and then I need to run to the next room." The patients feel very anxious, and it's harder for them to organize their thoughts. But if you come in and sit down in a chair, patients have a sense you're actually going to spend time with them. It sets the stage for better communication. So, there are some very simple things that physicians can do that can make a big difference.

CHM: Have you ever experienced poor physician communication from the patient side of the equation?

DM: Yes, I had back surgery a few years ago and I asked a colleague of mine, whom I had worked with for years, to do the surgery. I had some complications post-op, went

back for a post-op visit, and as I was sitting in the little examination room, he came in and said, "Okay, seems like everything's good." When I said, "Well, there is one problem," he dashed out the door and had his head sort of poked around the door jamb to listen to what the problem was and I thought, "I can't get his attention and I'm his colleague, I refer patients to him." You could tell he didn't want to hear what the problem was and was doing whatever he could to run to the next room. It was just astonishing to me. Unfortunately, doctors pride themselves on being very busy and very important, so patients sense that a lot of the rushing around and dashing in and out so quickly is because they're thinking, "I'm very important and I have to move along to the next patient so I can't deal with trivial things."

CHM: A final question: have you ever caught yourself being a poor communicator with a patient?

DM: Oh, yes; probably the worst incident was with a very nice older gentleman I'd been seeing for years. He was always doing fine, so we'd just renew his scripts. On one occasion, it was the end of the appointment, so there was nothing else to do. So I said facetiously, "I'm going to throw you out now." Meaning: "Your appointment is done." Well, he called the clinic two days later and said, "I don't know what I did to upset Dr. Marcus. She threw me out of the clinic. I can't come back. What am I going to do? Can you talk to her?" And the nurses came in to me and asked, "What happened?" "Nothing. What do you mean I threw him out of the clinic?" And then I remembered the exact words that I used. It's very easy for doctors to make flippant comments whose tone can be easily misinterpreted. During interactions with patients, you really need to monitor how you say things.

M

igraine miscommunications

Dawn A. Marcus, MD

Good treatment for migraine begins with accurate and open communication. Unfortunately, miscommunication between physicians and patients is a common problem, more common than most physicians appreciate.¹ Patients often leave consultations with their information needs unmet and their anxieties and concerns unrelieved. It is admittedly difficult to anticipate many patients' fears, because they may be biologically implausible. Nevertheless, miscommunication can have serious consequences, including dissatisfaction with medical care, poor compliance with treatment, and increased phone calls and appointments. Unmet expectations have been shown to

increase patient dissatisfaction by a factor of seven.² Conversely, patient satisfaction strongly correlates with perceived sensitivity to the patient's needs.³

Miscommunication may also be the result of patients misunderstanding headache terminology. For example, they may confuse the prodrome with the aura, or they might use the term *rebound* headache (which results from medication overuse), when they really mean *recurrent* headache, which can occur when the initial headache has been inadequately treated.

There is a considerable disconnect between what patients want and what physicians *believe* patients want (Table 1). A survey by Lipton showed that, at the top of the list for patients is a *willingness to answer questions*.⁴ However, physicians believe that *headache expertise* is what patients want most from them.

Strategies
for developing
effective
physician-patient
connections

Table 1.

Desirable attributes of physicians treating headache, in ranked order⁴

1

What patients want:	What physicians <i>believe</i> patients want:
■ Willingness to answer questions	■ Headache expertise
■ Teaches about treatment	■ Understanding and compassion
■ Educates about headache causes	■ Willingness to answer questions
■ Teaches headache avoidance techniques	■ Educates about headache causes
■ Headache expertise	■ Teaches about treatment
■ Understanding and compassion	■ Teaches headache avoidance techniques

Addressing patient fears directly

Communication improves markedly when physicians address patient fears directly. Patients with undiagnosed migraine often fear they have a tumor, stroke, or aneurysm, especially if family members or friends have suffered from one of these events. Thus, the patient needs to be told, “You have migraine headaches. Your tests show that you don’t have a brain tumor or any other life-threatening problem.” Relaying the positive benefits from migraine therapy alleviates fears and improves communication: “Today’s migraine treatments are effective and safe; most patients are able to return to normal activities within a couple of hours after taking a triptan.” However, there are pitfalls; a poor choice of words can mislead the patient. If the physician says, “We can treat your migraines with a medication I use for most of my headache patients,” the patient may think, “He’s going to prescribe the same old treatments that failed to help me in the past.” Or, if the physician says, “Remember triptans are very powerful,” the patient may think, “I’d better use them only when my headache is so bad I’m ready to go to the E.R.” The script in Table 2 illustrates the disconnect that can occur between spoken words and the meaning behind the words in physician-patient interactions.

Tools and techniques for effective communication

Studies have shown that simply providing written instructions can significantly improve communication.^{5,6} These instructions can identify specific treatment goals

that help patients monitor response to therapy. These goals include fast and complete pain relief, relief of functional disability, and identification of any side effects that reduce function or make the patient reluctant to use the therapy. The realistic goals of treatment with a triptan are: relief within one or two hours, complete relief of all migraine symptoms, and rapid return to normal function. The physician must be careful not to raise patient expectations too high, however: if you under-promise, you can over-deliver.

Figure 1 from *Lipton et al* shows what patients want most from their acute migraine medications.⁴ The three attributes considered most often by patients as *important* or *very important* were: complete pain relief, no recurrence of headache, and rapid onset of action. Treatment performance can be evaluated by direct questions targeted to these attributes: “Do you achieve partial or complete relief of migraine symptoms?” “Does your headache return within 24 hours after initial treatment?” “How long does it take for your medication to work? Is this fast enough for you?”

When words fail...

Even in the best of circumstances, verbal communication is often ineffective.⁷ When words fail, written materials can succeed. A study by *Fredrickson* showed that written educational materials provided prior to consultation increased patient perceptions of good communication occurring from 57% to 80%.⁸

Written communication tools can also facilitate diagnosis and assessment of treatment. One of the most useful is the migraine disability assessment scale (MIDAS) (Table 3), a relatively simple questionnaire that has been independently validated as an accurate tool for assessing degree of disability from migraine.^{9,10} Headache diaries are invaluable diagnostic tools; they can reveal headache features and patterns of medication use that even the patient may not be aware of.

♥ Studies have shown that simply providing written instructions can significantly improve communication. ♥ ♥

CHALLENGES IN HEADACHE MANAGEMENT

Table 2.

Migraine miscommunication: What They Say vs. What They Mean

2

What They Say...	What They Mean...
Doctor: Tell me about your headaches, Mrs. Jones.	<i>A new headache patient— and I'm already 20 minutes behind!</i>
Patient: Well, it all started when I was 3 years old...	<i>I brought 10 years worth of charts for him to review and he never even looked at them!</i>
Doctor: Yes, yes, that's fine. How frequent are your headaches? Do you have an aura?	<i>Doesn't she realize I've already read 10 years worth of records about her? Why did she bring all of these if she's going to tell me every detail that's in them anyway!</i>
Doctor: I see you brought your MRI scan. I'll show it to you. See, this is the brain, and this is the skull. And see these little white spots? They're high-signal intensity abnormalities on T2-weighted images that can occur with headache.	<i>This is a normal MRI scan. There are no tumors or abnormal blood vessels. Often small white spots are seen in patients with chronic migraine, but they are not a sign of any disease or damage.</i>
Patient: Oh.	<i>Does he think I have a brain tumor? Are those spots an infection?</i>
Doctor: Migraine is caused by abnormal blood vessels in the brain. Serotonin imbalance within the brain causes the blood vessels to react abnormally and cause headache.	<i>Migraine is not serious. There is no reason to worry.</i>
Patient: So will I need surgery? Is it serious? Is it fatal?	<i>Abnormal blood vessels! My uncle died of a brain aneurysm— is that what I've got? What's serotonin, and how did I get it?</i>
Doctor: You don't have any serious problem and you don't need surgery. Are you depressed?	<i>She's not even listening to me! She seems very anxious and high-strung. Could be a mood disorder—not unusual with chronic headache. Maybe that's why she's not focusing on what I'm telling her. Luckily some migraine medications treat both.</i>
Patient [with tears welling up in her eyes]: Not at all!	<i>Not again! My husband doesn't believe me, my boss thinks I'm a faker. I can't even find a doctor who'll take my headaches seriously.</i>
Doctor: For people with your particular condition, we often use antidepressants. And we'll have you meet with the psychologist. They have good treatments for you. Biofeedback and relaxation are also effective migraine therapies.	<i>She's in denial. Maybe this mood problem is more serious than I thought! Antidepressants are great headache preventive medications, so that would be a good choice.</i>
Patient: How do I take these?	<i>He really does think I'm just crazy. I'll try these pills and see if they help. I'm so desperate at this point I'd try anything!</i>
Doctor: Just take one pill before you go to bed and I'll see you back in 4 weeks.	<i>She needs to take this every day for several weeks before it will work.</i>
Patient: Okay. Before you go, I wanted to ask a few questions. Here's a list I wrote down for you.	<i>I wonder what the side effects are. I'll take it a couple of times and see if it works.</i>
Doctor: Here's a couple of pamphlets and we'll answer any questions you may still have at your next visit.	<i>She brought 4 pages of questions! I don't have time to answer 4 pages worth of questions today.</i>

Four weeks later

Doctor: Feeling better, Mrs. Jones? Now, you're still taking that pill every day, right?	<i>She's not complaining so the headaches must have improved.</i>
Patient: Uh, no. I just take it when I have a bad headache before I go to sleep like you said.	<i>It's not working at all! But if I complain you'll dismiss me as a patient and then what will I do?</i>
Doctor: I'll have my nurse come talk to you. Good-bye for now, Mrs. Jones.	<i>Oh, good grief! I specifically told her to take it every day! Maybe my nurse will get the medication instructions straight with her. I'll see her again in a couple of more weeks to check on things.</i>
Patient: Good-bye, doctor.	<i>That's it. I'm being dismissed by the nurse. He won't even speak to me. Time to find a new doctor.</i>

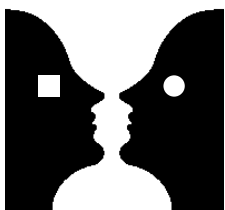
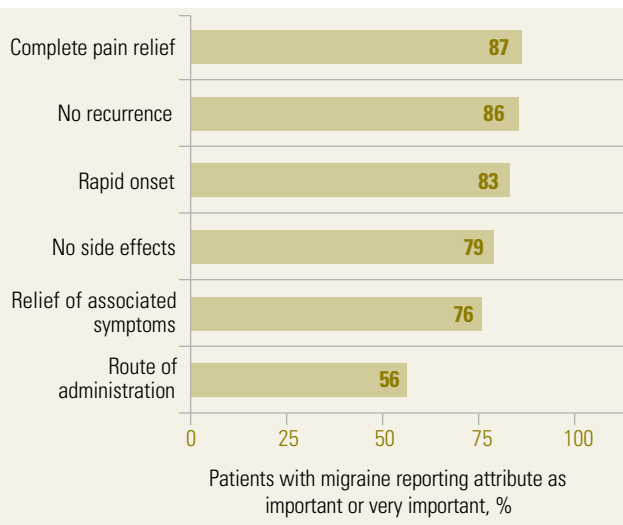


Figure 1.
What do patients want from their acute migraine medication?⁴

1



You can also improve communication with your patients by taking these simple steps:

1. **Build an open relationship over time.** Convey clear messages to your patient and encourage him or her to ask direct, specific questions, and make certain that your patient understands the answers.
2. **Help your patients learn as much as possible about your treatment plans.** Headache treatment can often be complicated and confusing for patients. Your or your nurse can educate your patients about medication instructions (written instructions will be most helpful for many patients).
3. **Stay focused on the most important questions.** Don't overwhelm your patient with too much information in a single visit.
4. **Encourage patients to share their concerns openly.** Many patients are reluctant to speak openly about their real concerns, perhaps out of fear that the news will be bad.
5. **Help patients learn as much as possible about their headaches.** Patients can be directed to internet web sites offering excellent patient education, such as the National Headache Foundation's site (www.headaches.org).

The accurate diagnosis and effective treatment of migraine and other benign headaches depend almost entirely on good physician-patient communication. For this reason, the strategies discussed here are more than simple ways to improve the human relationship — the good will — existing between physician and patient; they can play a key role in improving the practice of medicine.

Continued on back cover

The natural history of a migraine attack includes a number of discrete steps. It is currently believed that a dysfunction of the hypothalamus causes the prodrome, which is followed by a cortical spreading depression, which is responsible for symptoms of the aura, followed by activation and sensitization of peripheral nociceptors and activation and sensitization of second- and third-order neurons. This leads to cutaneous allodynia, which is defined as peripheral sensitization characterized by an extreme sensitivity to touch. Brain-stem activation then leads to the pain of migraine. Triptans have been shown to abort migraine attacks by acting directly on the mechanism of migraine. However, recent studies have shown that triptans are most effective when taken early in the migraine attack, before the development of cutaneous allodynia. In the following case report, the patient's failure to report her symptoms of cutaneous allodynia led to treatment failure.

Roberta C. is a 27-year-old woman who was diagnosed with migraine one year earlier. She had suffered from disabling headaches since age 19. Roberta's initial workup for headache led to an accurate diagnosis of migraine with aura. She had all of the characteristic symptoms: unilateral, throbbing head pain, extreme photophobia and phonophobia, nausea, and vomiting. She was greatly relieved to receive a definite diagnosis as well as the reassurance that her migraines could be controlled. She left with a prescription for a triptan and the expectation that her headache story would have a happy ending. Unfortunately, that wasn't the case.

Her triptan was effective only occasionally in aborting her headaches and she still suffered from frequent disabling migraines. Undeterred, her physician pointed out to her that lack of response to one triptan doesn't necessarily predict response to another triptan, so she was switched to another triptan brand. No luck, and this unfortunate situation continued for a full year and six different triptans before her physician stumbled on the answer.

After failing on six triptans, her physician essentially decided it was time to go back to square one and re-do the initial workup. This time, when Roberta described her symptoms, she added a detail she had neglected to mention during the first work-up: one of her symptoms was an extreme sensitivity to touch (cutaneous allodynia) on the contralateral head and ipsilateral forearm. She hadn't mentioned it before because her other symptoms were so much worse; in her mind it was a minor problem. On the other hand, her physician had failed to ask any questions that would have elicited a description of sensitivity to touch. But it was an important issue, one that would have affected the physician's choice of medication and directions for its use, because some medications, including the triptans may be less effective once cutaneous allodynia has begun. For Roberta, simply taking her triptan earlier during a migraine attack resulted in a substantial increase in efficacy. Unfortunately, a communication failure on the part of both patient and physician delayed effective treatment for a year.

**Case study:
a 27-year-old
woman with
migraine and
associated
cutaneous
allodynia**

CASE STUDY



CHALLENGES IN HEADACHE MANAGEMENT

Migraine miscommunications

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Table 3.
Migraine disability assessment scale (MIDAS)¹⁰

3

Instructions: Please answer the following questions about all the headaches you have had over the last 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months.

Grading system for MIDAS Questionnaire

Grade I Definition
Minimal or infrequent disability
Score 0-5

Grade II Definition
Mild or infrequent disability
Score 6-10

Grade III Definition
Moderate disability
Score 11-20

Grade IV Definition
Severe disability
Score 21+

1. On how many days in the last 3 months did you miss work or school because of your headaches?
 Days
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)
 Days
3. On how many days in the last 3 months did you not do household work because of your headaches?
 Days
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)
 Days
5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?
 Days
- A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than one day, count each day.)
 Days
- B. On a scale of 0-10, on average, how painful were these headaches (where 0 = no pain at all, and 10 = pain as bad as it can be)?

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