The Motives of the Patients in Preferring Complementary and Alternative Treatments within the Communication Context

Yasin Bulduklu
Assist. Prof. Dr.
Necmettin Erbakan University,
Faculty of Humanities and Social Sciences,
Public Relations and Advertising Department, Konya – Turkey
ybulduklu@konya.edu.tr

Abstract

Communication problems between doctors and patients lead to disappointment, nervous breakdown, and anger. As a consequence of this, patients usually get alienated from conventional health services and head towards alternative methods. The study aims to shed light on the attitude of people towards complementary and alternative medicine (CAM) and especially investigate the reasons why they go to bonesetters. Survey method was used to collect data. I designed a questionnaire form and sent it to 226 participants living in the city of Konya in Turkey. The data collected were analyzed using SPSS 15 software. This study indicated that the most significant incentive for visiting CAM therapists is the recommendation of relatives. The participants mostly utilized providers together with conventional treatment methods. Patients visits CAM providers with various reasons; why such as being shy with doctors, afraid of going to the doctors, assuming that the doctors don't care about them and don't pay attention to what do they say about their health problems. Another finding of this study is that there are four reasons that lead people to use CAM practises: "Communication/perception", "Conventional Support", "trial", and "dissatisfaction". CAM providers, in contrast to conventional medical professionals, are perceived as people who are appealing to physical, mental and emotional unity of patients. Patients prefer doctors who inform them as much as possible and behave sincerely. The attitudes of doctors towards patients and their communication skills affect the patients' preferences.

Key Words: Health Communication, Bonesetting Practices, Motives of Complementary and Alternative Medicine, Doctor-Patient Relationships

Introduction

The presentation of health services is a relational partnership regarding its nature. In this process, the quality of interaction between the ones offering health services and those benefiting from this service positively contributes to the effectiveness of the treatment along with increased patient satisfaction levels. There is a common consensus on the negative effects of poor communication between doctors and patients on the quality and results of healthcare services. Potential communication problems between a doctor and patient lead to disappointment, nervous breakdown, and anger of the patient towards the doctor (Kreps, 1985; Hughes, 2003; Macdonald, 2004; Roter & Hall, 2006; Bartlett, 2008; Havranek et al., 2012). As a consequence of this, patients usually get alienated from conventional health services and head towards alternative treatment methods.

The study, aims to shed light on the attitude of people towards CAM practices and investigate the reasons why they resort to alternative treatment methods, especially the bone setting practices.

More specifically, this study aimed to find answers to the following questions:

- Who goes to bonesetters?
- Have those people, visiting bonesetters received a medical treatment in advance or been receiving such treatments?
- What is expected from bonesetters?
- How satisfactory are alternative treatment fields?
- What do they think about doctors?
- What role do the communication problems play in their preference of visiting bonesetters?

The rest of the article is structured as follows: First, Human beings and alternative medicine: History of a controversial relationship. This is followed by a description of the research methods and procedures used in this study. Then the findings and results are presented. The article concludes with a summary of the study's research contributions and directions for the future research.

Human beings and alternative medicine: History of a controversial relationship

Manipulative treatments are methods that are first practiced on bones, joints, soft tissues, circulatory and lymphatic systems. Though these therapies are ancient, they have developed and become popular recently. Various categories are dealt with under these therapy types; the manipulative examples of which can be listed as the therapies carried out by touching the body such as massage therapy and body therapies (acupuncture, herbal massage, etc.) Likewise, some types of yoga, deep tissue massaging, Swedish massage and neuromuscular massage can be illustrated under this category as well. Craniosacral therapy and reflexology are manipulative treatment methods, in which the therapist smoothly palpates the patient's body, and focuses delicately on the communicated movements (Larson 2007:34; Bowling, 2007:80; Carroll, 2007: 31).

From conventional to alternative treatment: Offering patients a shelter to protect them from an unexpected storm

A study by Eisenberg et al., (1998) suggested that 50% of the patients resorting to alternative treatment providers visit massage therapists and chiropractors (Larson, 2007: 31). As Colinge stated (1987), the movement of lymphatic system is used for removing toxins, wastes, pathogens and tension and trauma on this system are treated by means of hands. When musculoskeletal system is considered, it is seen that the structure and functions of the body are all integrated. According to Larson (2007: 38), the development of all bodily functions depends on this cooperation, reducing stress and the movement of energy.

Conventional medicine (also referred to as Western or allopathic medicine) is the general name, given to biomedical methods practiced by medical doctors and other authorized healthcare professionals (psychologists, therapists or authorized nurses). Conventional medicine connects a disease to pathology which a part of the body. While defining this process Hughes (2003) says pathology contributes to the disease through practices and external factors that risk the health of an individual. Although there are some medical doctors that practice alternative treatments, most alternative treatment providers are out-of-field. These practices can both be transferred from father to son and are acquired through a mentoring system. Some people assume that these people have "innate talents." Although such practices are supposed to be charlatanism by most conventional medical professionals, their perception alters towards such treatments especially when they are sick. Complementary medicine refers to making use of such practices along with conventional medicine. Complementary medicine is practiced to reinforce conventional treatments (such as the use of aromatherapy after a medical operation to relieve pain). As some major studies indicated, in contrast to alternative medicine, conventional medicine encompasses operations (an operation recommended by a conventional doctor as a part of cancer treatment, choosing a special diet instead of radiotherapy or chemotherapy or utilizing herbal support products) rather than biomedical approaches (Bodeker & Kronenberg, 2002; Stone & Katz, 2005; Bowling, 2007; National Center for Complementary and Alternative Medicine, 2014; Larson, 2007; Carroll, 2007). Alternative medicine includes various treatment methods ranging from Zen Buddhism to acupuncture (Larson, 2007; Özçelik & Fadıloğlu, 2009). There have been 200 types of complementary medicine, the famous of which is assumed to be acupuncture and nearly the less known of which is auriculotherapy (Stone & Katz, 2005). Anthony Campbell (2002) illustrated four assumptions for all CAM practices to define components of CAM:

CAM is Natural: A good many treatment practices have emerged and gained substantial power due to health care's getting far more natural within the 20th century.

CAM is Traditional: It has been generally alleged that CAM practices, health and medicine date back to old times. Some complementary forms like conventional Chinese Medicine date back to thousand of years and have a threapeutic heritage.

CAM is Holistic: It is commonly believed that all types of CAM handle illness as a part personal integrity of patients. To put in a different way, a person is not solely a physical structure but has a pysical, mental and intellectual level. Hence, such synergy should be taken into account while delaing with illness. Illness is directly associated with the individual who is perceived as a whole.CAM is Energy: Energy practices are frequently purported with CAM practices. Such energy specifically indicate the energy, flowing around the body. Various therapies modify energy in diffrent ways, some of which can be sampled as Qi, Chi, pran and life energy.

CAM is Humanistic: CAM is straved in stone as human dignity and based on the presupposition that it has nonassignable rights. The personality of health is not only discreet but mental and social-sized at biological glance. The concern about medical technology's having nature, warding off human from individualism predominates CAM's perspective. Patient credit and honour are considered to be one of the utmost important components of CAM practically in all CAM practices.

CAM is Fundamentally Curative: In most of CAM practices, the belief in which it is merest response to natural running of the body is supposed to be the best

therapy rules over most of CAM practices. This is somehow the reflection of the perspective that the body transfers energy for self- remedy. The aim is to recover illness with minimal therapy. In addition, the aim is to soothe treatment addiction.

Patients and doctors: a relationship without communication

Issues regarding the presentation quality of health services and its communicative elements have recently been at the core of the discussions in the international literature. Recent studies indicate that health care providers should guarantee open channels of communication so as to enable patients to speak up about factors affecting their trust (Ngo-Metzger et al., 2006, DeVoe et al., 2009). It is commonly noted that most people seeking alternative treatments claim that the ones, providing such treatments are far more optimistic and positive than the conventional medical professionals (Korsch & Hardling, 1997; Budd & Sharma, 2002; Schofield, 2004; Snyder, 2007; Nguyen & Bowman, 2007).

The predictive factors, shaping a patient's evaluation of the service, offered are the sincerity of health service providers and their interest. This is closely related with the communicative skills of the people offering the service. To illustrate, a patient, not contended with the communication with the doctor naturally tend to be in search for complementary and alternative ways. The quality of medical equipment of the healthcare institution, offering the health services, professional experience of the healthcare professionals and the nature of their skills are self-perceived. In this context, what counts important is the level of patient satisfaction that makes itself clear during the service. Interaction of drugs, medicated or their side effects and lack of communication between doctor and patient are supposed to be key factors of CAM practices. Studies on this issue stress that doctors that are natural healthcare service providers have limited communicative skills, and they are not skilful enough at listening to and interacting with their patients. A major study (Schofield, 2004) had evidences that the reason of the increase in popularity of CAM therapies is because of inadequate communication skills of the conventional providers. Another study (Snyder, 2007) indicated that conventional providers can cause stress on patients. Concordantly, the major reason for the increase in the popularity of alternative medicine is regarded to be the tension the medical professionals stir up during medical encounters and lack of their communicative skills. Communication between CAM providers and patient is peer to communication when compared with conventional doctor-patient relationships. Apart from asymmetric relations between doctor and patient, the other factors such as professsionals are not sparing enough time for patients, in reducing side effects of drugs, getting rid of despair, overcoming tension, high cost of new technology and strains of acquiring such facilities, dissatisfaction with conventional treatment enforce patients to seek alternative ways. (Kroesen, et al., 2002: 62; Özçelik & Fadıloğlu, 2009: 49).In addition, it is commonly noted that most people seeking alternative treatments claim that the ones, providing such treatments are far more optimistic and positive than the conventional medical professionals (Korsch & Hardling, 1997; Budd & Sharma, 2002; Schofield, 2004; Snyder, 2007; Nguyen and Bowman, 2007).

Although, lack of communication abilities of some health professionals causes the patients to look for alternative ways for treatment, they still don't stop visiting doctors. They use both treatment methods as Nazik et al (2012) stated:

> "…a significant number of patients with gynecologic cancers prefer CAM techniques as an additional therapy to modern cancer therapy".

Method

In this study, descriptive literature review and survey method was used. The target population for this study consisted of patients who prefer to visit the bonesetters instead of doctors. I designed a questionnaire form carrying open-ended questions and sent it to 226 participants, by mail, living in the city of Konya in Turkey. Key (1997) defined questionnaire form as "a very concise, preplanned set of questions designed to yield specific information to meet a particular need for research information about a pertinent topic". Many scholars employed questionnaires method in their studies as Colosi (2006) pointed out, "Questionnaires are the most commonly used method for collecting information from program participant".

The questionnaire form I designed was made up of four sections. The first section consisted open-ended questions aiming to analyze disease models of individuals, the second section involved items to find out the reasons why the participants visit the bonesetters or go to the doctors, the third section was comprised of 5 point scale questions, embodying judgments on communicative competence of the bonesetters and the doctors. This section's questions, 26 item scale, aimed to find out respondents' attitudes toward use of CAM. Participants were asked to indicate their level of agreement with items on a 5 point Likert Scale ranging from 1 = "strongly disagree" to 5 = "strongly agree." And finally the questions in the fourth section were designed to identify socio-demographic attributes of the participants.

The initial questionnaire developed after an extensive research on the results of previous research studies with the similar focus and studying on the relevant literature carried 31 questions. This questionnaire was tested on 32 people. Then I made some revisions and discarded the items with low reliability values. The final questionnaire form that had 22 questions was sent to 226 participants. Participants were selected among visitors to a bonesetter living in the city of Konya in Turkey. This survey was conducted between the dates of March, 2012 and September, 2012.

Statistical analysis was performed after the data collection. In this context frequencies were used to describe the variables and characteristics of participants. Chi-square analysis was used to detect differences in reasons of visiting bonesetters. The statistically level was accepted as p= 0.05. Finally, factor analysis was performed; reliability analysis was performed for each factor.

Findings

Male participants preferred bonesetting practices more frequently than females.

A great majority of people, visiting bonesetters are at the age of 40 or above. As the level of education and income of the participants go up, they visit bonesetters less frequently.

The participants mostly utilized bonesetting practices together with conventional treatment methods.

The participants usually prefer to visit bonesetting practices at the initial stage of their problems.

Various factors, such as being shy with doctors and thinking that the doctor's will not care aboutand listen to them, affect their alternative treatment methods preference.

Recommendations of acquaintances and relatives play a significant role in preferring for bonesetting practices.

Discussions and results

The results of relevant literature review and the survey conducted during this study pointed out that lack of communication between doctors and patients plays an important role on the patients' decision of choosing the alternative treatment practices.

Some researchers argue that CAM provider has more positive personality and optimistic attitude than conventional ones (Korsch & Hardling, 1997 Budd & Sharma, 2002).

Present study findings show that the less important factor of the participants' visiting CAM provider or a bonesetter was "dissatisfaction" with conventional treatments. Study findings also indicated that the participants, who complain about the behaviour of doctors, do not trust them and think that bonesetters have divine powers.

A major study (Schofield, 2004) had evidences that the increase of the popularity of CAM therapies is because of inadequate communication skills of the conventional providers. Current study findings are consistent with both studies, mentioned above (See Table 3).

Similarly Table 4 results indicated patients who are not satisfied since because they cannot communicate with doctors, prefer to go CAM practices. According to Carrol (2007), people can easily access to communication technology due to expanded Internet. Correspondingly, people may have a lot of information about their health. In other words, today's' people have the ability and the means to question about the treatment methods. Nowadays, many people do research whether given drugs useful for their treatment. It's obvious that, many drugs are withdrawn from the use because of side effects on human health. That's why people tend to seek alternative treatment methods for their health. Present study findings showed that people prefer CAM applications for the same reasons.

The overall findings of the study are discussed below:

It was seen that male participants preferred bonesetting practices more frequently than females. This might be related with the traditional female-male relations and the roles they play in daily life in Turkish society. In an atmosphere where women do not prefer male doctors unless it is absolutely necessary, they are not expected to visit male bonesetters. In this regard, the findings of our study are highly interesting. This is because there are a considerable number of women, visiting male bonesetters. A great majority of people, visiting bonesetters are at the age of 40 or above. This finding does not mean that younger people do not visit bonesetters. 36% of the participants are below 40 so this might imply that the idea of preferring bonesetting practices is getting widely adopted in Turkish society. The participants mostly utilized bonesetting together with conventional treatment methods (Mean: 4.28).

The participants usually prefer the bonesetting practices at the initial stage of their problems. Our study findings indicate that various factors, such as being shy with doctors and thinking that the doctor's will not care about and listen to them, affect their alternative treatment methods preferences. Another finding of this study is that recommendations of acquaintances and relatives play a significant role in choosing the bonesetting practices (%68.4) (See Table 2). Establishing close relationship is very common in Turkish society, especially among people living in rural

areas or people with a rural background in certain parts of urban areas. Sincere communication styles are common. As a consequence of this, any information spread among people mostly in the form of gossip. In this regard, personal experience as a piece of advice is extremely important for orientation in daily life (p=0.00). (See Table 4).

In the factor analysis of the data, collected from the participants, the criteria of eigenvalues with varimax rotation over 1 and minimum loading size of .30 were applied and 44.69% of the variance was explained. Therefore, 4 factors were obtained. The first factor was referred to as ”Communication / Perception”. The total variance was mostly explained by the factors such as the perception that bonesetters speak the same language with the patient, receiving the treatment as the most critical factor in visiting a bonesetter, their giving detailed information about the disorder, patients' not being pleased with the attitudes of doctors, less severe side effects in bonesetting practices or the belief that such practices are harmless in contrast to conventional treatments. Therefore, the most important motive is that individuals are not satisfied with the quality of communication with the doctor, and they substitute doctors with bonesetters.

The second factor was referred to as ”Conventional Support”. Some of the people visiting bonesetters also receive conventional medical treatment. These people believe that bonesetting practices provide at least psychological improvement.

The third factor was referred to as ”Trial”. According to the items under this factor, people prefer alternative treatment practices as the last chance or thinking that they are harmless.

The less important factor as the last motivation for the participants' visiting a bonesetter was referred to as ”Dissatisfaction” with conventional treatments. The participants complain about the behaviour of doctors; they do not trust doctors and think that bonesetters have divine powers.

The data collected in the study and the findings obtained are presented below in the form of tables within the framework of the questions in the study, and they are interpreted.

Table 1. ***Socio-demographic characteristics of the participants***

	N	Min.	Max.	Mean	Std. dev.
Age	266	19	75	45.35	12.863
Income	266	400	7500	1629.17	1309.817
				F	**%**
Gender	Female			154	42.1
	Male			112	57.9
Age	19-29			32	12.0
	30-39			64	24.1
	40-49			52	19.5
	50-59			78	29.3
	60-69			30	11.3
	70 and above			10	3.8
Educational background	Uneducated			20	7.5
	Primary School			114	42.9
	Secondary School			48	18.0
	High School			42	15.8
	University			42	15.8
Income	400-1000			138	51.9
	1001-2000			78	29.3
	2001-3000			22	8.3
	3001-4000			16	6.0
	4001-5000			6	2.3
	5001 and above			6	2.3

The participants' ages vary between 19 and 75, and they have a monthly income of 400-5000 Turkish liras. 57.9% of them are males, while 42.1% are females. Unlike what is commonly considered men used to visit bonesetters more frequently than women did. 36.1% of the participants were between 19 and 36 years old. 63.9% of them were at the age of 40 and above.

Table 2. ***Information about the disorder***

		Frequency	Percent
Visiting a doctor in the last *one year* period	Yes	222	83.5
	No	44	16.5
The use of medication with the treatment	Yes	114	42.9
	No	152	57.1
The duration of the complaint	Less than a year	138	51.9
	Between 1-2 years	54	20.3
	Between 2-4 years	18	6.8
	Between 4-6 years	18	6.8
	Between 6-8 years	22	8.3
	More than 8 years	16	6.0
Continuing to visit a doctor	Yes	100	37.6
	No	166	62.4
The type of the disorder	Lower back pain	174	65.4
	Neck pain	48	18.0
	Shoulder, knee, other joint or extremity problems	44	16.6
A relative's use of and benefiting from alternative treatments	Yes	182	68.4
	No	20	7.5
	Does not know	64	24.1

Almost all participants have received a conventional treatment to cure their illness within the last one year period. In addition to this, they have visited a bonesetter. More than half of them visit a doctor along with utilizing a bonesetter. Most of these people do not practice the treatment given by the doctor at all or they give it up. Patients opt for the practice of bonesetting or other alternatives just at the onset of their problem. As it is expected, the reason for visiting a bonesetter is mostly lower back problems. 68.4% of the participants have visited a bonesetter and benefited from the treatment. The most significant incentive for visiting bonesetters is the recommendation of relatives.

Table 3. ***Motives for using bonesetting practices***

I visit a bonesetter.	Mean	Sd.	Factors 1	2	3	4
Communication/Perception						
I don't understand what my doctor tells me.	3.71	1.090	.715			
Doctors also believe in these treatments.	4.04	1.088	.655			
Gives detailed information	3.89	.972	.617			
I haven't been satisfied with my doctor's attitude.	3.86	1.127	.615			
People who have tried these treatments have benefited from Them.	3.85	.940	.588			

Explains my disorder as I can understand.	4.24	.769	.575			
I believe that it has fewer side effects in contrast to conventional treatments.	3.92	1.092	.513			
I cannot reach my doctor.	4.26	1.020	.448			
I recommend alternative treatments, too.	4.02	.860	.415			
Alternative treatments do not have medical drawbacks.	3.95	1.059	.385			
The bonesetter spares more time for me.	3.95	.910	.374			
Healthcare professionals visit bonesetters, too.	4.22	.906	.422			
Support						
Alternative treatments psychologically help me.	3.73	1.266		.751		
Alternative treatments should be practiced with conventional ones.	4.28	.954		.611		
Doctors work much.	3.84	1.091		.563		
Doctors should recommend such therapies.	4.01	1.039		.522		
Alternative treatments are a type of physiotherapy.	3.62	1.040		.471		
Such practices are to be more common in the future.	3.85	1.102		.455		
Alternative treatments should be carried out under the control of Ministry of Health.	4.22	.946		.432		
Alternative treatment training should be given, too.	4.34	1.020		.420		
Trial						
I will visit my doctor after this last chance.	2.76	1.324			.751	
I am against such practices too, but I want to try.	2.36	1.108			.736	
It is neither beneficial nor harmful.	2.32	1.032			.615	
Dissatisfaction						
I do not trust doctors.	2.86	1.260				.757
Doctors do the same things, too.	2.96	1.343				.745
People who practice these treatments have spiritual powers.	3.07	1.217				.482
Eigenvalue			*5.86*	*3.54*	*2.11*	*1.79*
Variance Explained (%)	*44,69*		*19.70*	*11.91*	*7.08*	*6. 00*
Reliability (Cronbach's Alpha)	*.733*		*.821*	*.703*	*.682*	*.546*

The motives for benefiting from bonesetting practices are composed of 26 items. After the survey was conducted, these 26 items were analyzed to identify the factors concerning the motives for visiting bonesetters. Reliability analysis indicated that the scale was reliable enough (.733). In the factor analysis, acquired from the participants, the criteria of eigenvalue with varimax rotation over 1 and minimum loading size of .30 were applied; the motives for going to bonesetters explained the 44.69% of the variance (See Table 3).

The first factor was referred to as "Communication/perception". Various issues are included in this factor such as the belief that bonesetters speak the same language with the patient receiving the treatment as the most critical factor in visiting a bonesetter, their giving detailed information about the disorder, patients' not being pleased with the attitudes of doctors, less severe side effects in bonesetting practices or the general perception that such practices are harmless in contrast to conventional treatments. The participants resort to bonesetters mainly due to their belief in which they can communicate with bonesetters better than they do with doctors. Based on communication skills, the

motive for visiting a bonesetter explains 19.70% of the variance on its own. The reliability of the items under this factor was calculated to be .821.

The second factor is "Support for Conventional Treatments." Some of the people visiting bonesetters also receive conventional medical treatment. Such people believe that bonesetting practices help them improve psychologically and doctors cannot allocate enough time because of justifiable reasons. They note that they will be pleased when doctors direct them to alternative treatments; they also state that they support potential legal regulations concerning this issue. This factor accounts for 11.91% of the total variance, and the reliability coefficients of the items in this group is .703.

The third factor explains 7.1% of the total variance and it is called as "Trial." According to the responses to the items within this factor, people have chosen this practice as a last chance prior to conventional treatment practices. People actually want to try bonesetters with the idea that they will give no harm to them. There are three items under this factor, and the reliability coefficient of this factor was found to be .682.

The less important factor as the last motivation for the participants' visiting a bonesetter was referred to as "Dissatisfaction". The fourth factor explains 6% of the total variance. The reliability coefficient of this factor was found to be .546.

Table 4. ***Reasons of visiting bonesetter***

	I rely on my doctor	F	%	p
People who practice these treatments have spiritual powers.	Yes	74	27.8	0.003
	No	192	72.2	
People satisfied with my relatives and family from bonesetter.	Yes	92	34.5	0.00
	No	174	65.5	
According to me, CAM is no threatens on human health.	Yes	86	32.3	0.005
	No	180	67.7	
I had gone to the doctors before, but they couldn't to solve my problem.	Yes	114	39.8	0.002
	No	172	60.2	

The participants do not trust doctors on the grounds that their problems are not solved when they visit doctors, and not enough time is allocated for them, so they go to bonesetters. The participants contrast the bonesetter with doctor and believe that the former has spiritual powers. According to the results of Chi-square analysis, the participants believe that the bonesetters have spiritual power that has been. They think that bonesetting practices or CAM do not threaten their health even if there are no benefit.

Conclusions

Patients prefer doctors who inform them as much as possible and behave sincerely. The attitudes of doctors towards patients and their communication skills affect their preference. This plays a critical role in visiting the doctor and continuing the treatment. On the other hand, when doctors do not attach enough importance to empathy and effective communication in doctor-patient relations, patients seek for alternative methods. People believe that providers of complementary or alternative practices like bonesetting provide them with some benefits that medical professionals cannot give.

In all conventional or alternative therapies, effective communication and establishing the perception of patients is incorporated into the treatment process are the key elements of successful treatment as it is the case in other face-to-face practices. It can be said that the communicative nature of the practice of bonesetting and other alternative methods is more flexible in comparing with conventional treatment methods. Patients are more inclined to communicate with alternative treatment providers, while they keep doctors at a distance. The feeling of being humiliated and not being a part of the treatment process plays a critical role in this. This situation does not have a one-way explanation. In this process, it cannot be said that only doctors are responsible for this result on account of their attitude towards patients. Patients play an important role as well. Most of the time, patients view doctors far more different and distant from themselves, especially at the beginning of the treatment process, and they behave regarding the assumption that the doctors will fail to understand them. Patients' or their relatives' past experience with doctors lead them to such assumption. It is certain that this is prejudiced attitude, in turn, affects

doctor-patient relations negatively. Therefore, it seems inevitable that doctors be informed or trained about healthcare communication. Notwithstanding the recent reforms in the healthcare field, it is thought-provoking that patients still have such a perception.

Scholars who want to make further research on the same field may study on measuring the perceptions of the ability to communicate of the health professionals and alternative medicine practitioners by forming two sample and control groups. Since this study is about the alternative medicine practices conducted by bonesetters, future studies can be on different alternative practices in the context of communication and satisfaction and this may contribute to science.

References

Bartlett, G., Blais, R., Tamblyn, R., Clermont. R.J., MacGibbon, B. (2008). Impact of patient communication problems on the risk of preventable adverse events in the acute care settings. *Canadian Medical Association Journal. June* 3;178(12):1555-1562.

Bodeker G, Kronenberg F. (2002). A public health agenda for traditional, complementary, and alternative medicine, *American Journal of Public Health*, October 2002, 92(10), 1582-1591.

Bowling, A.C. (2007). *Complementary and Alternative Medicine and Multiple Sclerosis*. Second edition, NY: Demos Medical Publishing.

Budd, S., Sharma, U. (2002). Introduction. In Susan Budd and Ursula Sharma (Eds.), *The Healing Bond: The Patient- Practitioner Relationship and Therapeutic Responsibility* (pp.1-19). NY: Routledge.

Campbell, A. (2002). Complementary and alternative medicine: Some basic assumptions, In *Alternative Medicine, Should We Swallow It?,* Heller, T., Lee-Treweek, G., Katz, J., Stone, J., and Spurr, S. (Eds.). (pp. 1–14).London. Hodder & Stoughton Publisher.

Carroll, R.J. (2007). Complementary and alternative medicine history, definitions, and what is it today?. In Lois Snyder (Ed.), *Complementary and Alternative Medicine Ethics, the Patient, and the Physician* (pp. 1-6). Humana Press Inc.

Colosi, L. (2006). *Designing an effective questionnaire*. Cornell Cooperative Extension. Retrieved on September 15, 2013 from http://www.human.cornell.edu/pam/outreach/parenting/research/upload/Designing-20an-20Effective-20Questionnaire.pdf

Corbin, L. (2005). Safety and efficacy of massage therapy for patients with cancer. *Cancer Control*, July 2005, 12 (3), 158-164.

DeVoe, J.E., Wallace, L.S., and Fryer, G.E. (2009). Communication with healthcare providers: do differences in demographic and socioeconomic characteristics matter? *Health Expectations*, 12(1), 70-80.

Havranek, E.P, Hanratty, R., Tate, C., et al., (2012). *The effect of values affirmation on race-discordant patient-provider communication*. American Medical Association, published online November 5, 2012, Retrieved on August 14, 2013 from https://ed.stanford.edu/sites/default/files/values_affirmation_-_final.pdf

Hughes, K. (2003). Health as individual responsibility possibilities and personal struggle. In Philip Tovey, Gary Easthope and Jon Adams(Eds.), *The Mainstreaming of Complementary and Alternative Medicine Studies in Social Context* (pp.34-52). London: Routledge,

Korsch, B. M. and Harding, C. (1997). *The Intelligent Patient's Guide to the Doctor-Patient Relationship, Learning How to Talk so Your Doctor will Listen*. Oxford University Press.

Key, J. P. (1997). *Research Design in Occupational Education*. Oklahoma State University. Retrieved on February 4, 2014 from http://www.okstate.edu/ag/agedcm4h/academic/aged5980a/5980/newpage16.htm

Kreps, G.L. (1985). *Interpersonal communication in health care: promises and problems*. Annual Meeting of The Eastern Communication Association 76th Providence Rhode Island, May 2-5.

Kroesen, K., Baldwin, C.M, Brooks A.J. and Bell, I.R. (2002). US military veterans' perceptions of the conventional medical care system and their use of complementary and alternative medicine. Family Pract. February 2002, 19 (1), 57-64.

Larson, C. (2007). *Alternative Medicine*. London: Greenwood Press.

Macdonald, L. (2004). An introduction to basics. In Elisabeth Macdonald (Ed.), Difficult Conversations in Medicine (pp.1-4). NY: Oxford Un. Press.

National Center for Complementary and Alternative Medicine, Complementary, alternative, or integrative health: what's in a name? *CAM Basics*. (2014). Pub No.: D347. Retrieved on May 20, 2014 from http://nccam.nih.gov/health/whatiscam/D347.pdf

Nazik,E.,Nazik,H., Api, Kale, Aksu. (2012). *Complementary and Alternative Medicine Use by Gynecologic Oncology Patients in Turkey*. DOI:http://dx.doi.org/10.7314/APJCP.2012.13.1.021

Ngo-Metzger, Q., Telfair, J., Sorkin, D. H., et al. (2006). *Cultural competency and quality of care: obtaining the patient's perspective*. The Commonwealth Fund. Retrieved on October 12, 2013 from http://www.commonwealthfund.org/Publications/Fund-Reports/2006/Oct/Cultural-Competencyand-Quality-of-Care--Obtaining-the-Patients-Perspective.aspx

Nguyen, G.T., Bowman, M.A. (2007). Culture, language, and health literacy: Communicating about health with Asians and Pacific Islanders, *Family Medicine*, 39 (3), 208-210.

Özçelik, H., Fadıloğlu, Ç. (2009). Kanser hastalarının tamamlayıcı ve alternatif tedavi kullanım nedenleri. *Türk Onkoloji Dergisi*, 24(1), 48-52.

Roter, D.L. and Hall, J.A. (2006). *Doctors Talking with Patients/Patients Talking with Doctors Improving Communication in Medical Visits*.

Second edition, Greenwood Publishing Group, Inc.

Schofield, T. (2004). Preface. In Elisabeth Macdonald (Ed.), *Difficult Conversations in Medicine* (pp. xv-xvi). NY: Oxford University Press.

Snyder, L. (2007). A Context for thinking about complementary and alternative medicine a ethics. In Lois Snyder (Ed.), *Complementary and alternative medicine ethics, the patient, and the physician* (pp. 1 - 6). NJ: Humana Press Inc.

Stone, J and Katz, J (2005). Can complementary and alternative medicine be classified?, In *Perspectives on Complementary and Alternative Medicine*,Tom Heller Geraldine Lee-Treweek, Jeanne Katz, Julie Stone and Sue Spurr (Ed.) (pp. 29-51), UK Routledge Taylor & Francis Group in Association with Open University,