

Seventy-Five (Count 'Em—75!) Issues of *Health Communication*: An Analysis of Emerging Themes

I first began discussions with Lawrence Erlbaum Associates, Inc., about the possibility of a journal focusing on health communication in November of 1986. After we decided to move ahead with the project, I prepared a proposal, which was accepted, and began receiving submissions for the journal in the fall of 1987. Here we are now—75 issues later! A lot has happened in between our first call for papers and the submission of this 75th issue to the publisher. As I move on to discuss those things that have happened, I'd like to begin with a very large thanks to Lawrence Erlbaum Associates, Inc., and the wonderful personnel, production editors, copy editors, and so on, with whom I have worked for these many years. Special thanks are extended to Jean Cassidy, Eddie Bates, and Linda Bathgate.

Now, back to business. The initial submissions to the journal were slower than they are now, and many were of questionable quality—a bit of “new editor, new journal” syndrome, in which people submit pieces they've had sitting in the bottom of a file drawer to any new journal or editor that comes on the scene. Our reviewers, rigorous from the very beginning, didn't accept many of those initial submissions. I solicited most of the articles for the flagship issue, wanting that first one to appropriately set the stage for a journal that would become an important force in the field. That process was a successful one, and those articles from Issue 1, written by such scholars as Barbara Korsch, David Smith, Gary Kreps, Jon Nussbaum, Paul Arntson, and Kathleen Reardon, are still frequently cited by scholars. The goal of that issue was to set an agenda for future health communication research—a goal that was accomplished. A recent survey in the *Handbook of Health Communication* comparing the exhortations for research provided by those scholars with the kind of work that has been done since indicated fulfillment of the recommendations and directions that had been offered within those pieces (Thompson, 2003).

After we went through that initial set of submissions, the quality of work that was sent in improved noticeably and continually. That trend has continued over the years, with a continuous improvement every year in the quality and quantity of submissions. I make my assessment of improvement on the basis of reactions of our reviewers to the sub-

missions we receive—they respond affirmatively to a larger number (although a smaller percentage) of submissions each year—as well as on the basis of my own reading of the submissions. The actual numbers of submissions continue to increase, too. We've now increased the size of the journal four or five times—I've lost track—and are up to six issues per year of a larger format with increased length. When Taylor & Francis began the *Journal of Health Communication* in the mid-'90s, I was originally afraid that our submissions would decrease, but that never happened. The quality of the work in the area of health communication is so strong that two journals could easily be supported, both in terms of submissions (quality and quantity) and in terms of subscribers. Both journals have such a backlog of high-quality accepted pieces that many scholars no doubt wish there weren't so much good work being done—they'd like their own work to find its way into print more quickly. And the number of accepted submissions is no reflection of a lack of rigor in the review process. Our reviewers have always been selective, thorough, careful, and demanding. Many authors have had to go through multiple revisions before a decision for acceptance was offered. Our acceptance rate has been around 15% for many years now. Of importance, I always feel pretty darn good about an issue as I proof it; the quality and contributions made by the articles are strong. Our impact rating supports this assessment, in that *Health Communication* was ranked No. 8 out of 44 communication journals in 2003—higher than *Journal of Communication*. A recent Web of Science analysis indicated that *Health Communication* was 7th out of 17 communication journals (including the 7 International Communication Association and National Communication Association journals and the others most closely related to them on the Web of Science) in the past 3 years and was 6th of 17 in “improvement” in that same time frame (Feeley, 2006).

The types of submissions that I've received have, of course, changed over the years. Initially, almost all of the submissions I received focused on interpersonal aspects of provider–patient interaction. Indeed, many people mistakenly believed that the journal was intended to focus only on such issues, although our editorial and mission statement clearly stated that our focus was much broader. Slowly, however, word must have gotten out that we were interested in *all* kinds of health communication scholarship, and our submis-

sions began to reflect this. A recent analysis of articles published in the journal from 1989 to 2003 reported that 20.7% of the pieces have focused on patient–physician interaction, 13.4% on health campaigns, 11.8% on risk, 8.4% on aging, 7% on language (focusing on language that creates or does not create shared meaning), and 5.9% on media issues. Other topics that have been covered include social support, inter- or multicultural concerns, technology, families, health information, end-of-life concerns, and pediatrics (Thompson, Robinson, Anderson, & Federowicz, in press). We’ve seen notable increases in research on aging, technology, and language issues over the years.

In terms of health problems, the research that was published in the early years of the journal emphasized cancer, substance abuse, and the area of HIV, STDs, safe sex, and family planning more than any other topics. Those three issues were the focus of almost 75% of the articles in the first 5 years of the journal. Since that time, the foci have broadened appreciably. The broadening of focus in health communication work is perhaps the most notable trend in the area of study, and one to which I will return later in this discussion.

The types of research methods that were used also changed over time, with experimentation originally being the most popular method but gradually decreasing in frequency of use. Content analysis has become less popular, but survey research, behavioral coding, and multiple methods have become much more popular than they were. We’ve seen much more emphasis on conversation and discourse analysis and on ethnographic, qualitative, narrative, and rhetorical work over the years. These have provided welcome and important additions to our understanding of health communication processes, as have the recent additions of critical and cultural analysis of health communication work.

When I recently selected three senior editors for *Health Communication*, I invited Lynn Harter to focus upon narrative, qualitative, and rhetorical work, Mohan Dutta to handle critical and cultural submissions, and Mike Stephenson to emphasize campaigns and media issues (primarily quantitative work). I will continue to handle the interpersonal issues myself. After sending out an e-mail to all of the people I commonly use as reviewers, and the members of our editorial board, I received a response from one scholar expressing concern about whether I had a quota of articles I would accept from the three areas represented by the new senior editors. Although I had chosen them because I was receiving a far greater number of submissions from those areas, there was never any intention to make sure that all areas were “equally” represented. Of interest, since that time I’ve found that I’ve been overwhelming Mike Stephenson and not keeping Lynn Harter or Mohan Dutta busy enough! Although we’re finding more work in the areas Lynn and Mohan will cover, the quantitative work still far exceeds the qualitative or critical and cultural work.

Although an examination of just *Health Communication* and the *Journal of Health Communication* would lead one to conclude that much of the field focuses on health campaigns and promotion, a broader look at journals that publish research related to health communication gives one a different view. Since late 2004 (*Health Communication*, Volume 16, Issue 4), Bill Evans has been compiling and publishing bibliographies of work on health communication from dozens of databases that index thousands of journals across a variety of fields and publishing them for readers in *Health Communication*. For this I’d like to provide very big thanks to Bill. This effort is a monumental one—I think even bigger than Bill anticipated it would be when he first approached me with the idea! It’s yet another sign of how very much research in the area has grown. Bill typically groups the articles in the bibliography into the following categories: health campaigns and promotion, health communication theory and research, health information and informatics, health risk, mediated health communication, and interpersonal aspects of health communication. In the bibliographies published since the beginning of 2005 (*Health Communication*, Volume 17, Issue 1, and on), interpersonal work (focusing primarily but not exclusively on provider–patient interaction) has accounted for 32% of the articles identified in the bibliography ($n = 290$ of 914). Articles on mediated communication encompass 25% ($n = 232$) of the pieces, while those on health information and informatics represent 17% ($n = 154$). The other three categories account for 13% (health communication theory and research, $n = 120$), 7% (health risk, $n = 69$), and 5% (campaigns and promotion, $n = 49$). It is notable that an area that seems to account for a large percentage of the articles in *Health Communication* and, more recently, the *Journal of Health Communication* (health campaigns and promotion) is the area that is the smallest in the field of health communication as a whole. It appears that it is health communication scholars with actual backgrounds in the field of communication who provide a primary focus on health campaigns and scholarship.

Although the category of health communication theory and research as categorized in the bibliographies accounts for 13% of the published work, an examination of those pieces indicates that few actually focus on theory development. That categorization is necessarily a loose one. Those pieces provide theoretical application, for the most part, rather than offering new theoretical frameworks for health communication inquiry. Over the years we’ve seen more work that includes theory testing but still little new theory development. Indeed, one of the increasing strengths that we’ve seen in articles submitted to and accepted for the journal over the years has been a much stronger reliance on theoretical framing of research. It is rare that our reviewers will accept a piece that is atheoretical. This is one of the difficulties faced by nonsocial science scholars attempting to conduct research on health communication. Whereas social scientists are trained

to frame research with a theoretical background, those trained in medicine are less likely to have been taught to focus in that way. This makes sense, of course, in that most medical research focuses on health problems rather than broader social, relational, or communicative issues or processes. Theory isn't terribly relevant for an analysis of a particular health problem (this is arguable, of course), but it is important for an examination of communicative issues and processes. The generalizability of research is noticeably increased when it is framed by a theory, however, in that one learns something not just about that health problem, but also about a broader communicative process. That finding can then potentially be applied to other health problems or concerns.

The lack of theory development in health communication journals may also be seen in a positive light. Those theories that are used in health communication are theories that explain communicative phenomena, not just health communication behavior, and are typically published in communication journals with a broader focus rather than those that emphasize just one context of communication (such as health communication). For instance, Austin Babrow's (1992) problematic integration theory was first published in *Communication Theory*, but has been applied more frequently in health communication than in any other area of the field.

Although the work reported above indicates some notable activity in the study of health communication, other analyses indicate a lack of prioritization of health communication work in mainstream communication journals (Beck et al., 2004, p. 483). Beck et al. examined 19 journals over an 11-year period. Two of those journals focused exclusively on health communication (*Health Communication* and *Journal of Health Communication*) or on health in other ways (*Qualitative Health Research*), and the remainder were broader communication journals. Of the 5,506 articles the authors examined, 15% focused on health communication. Most of those articles, however, were in the two health communication journals or in *Qualitative Health Research*. Apart from those journals, only 4% of the published articles focused on health communication. Beck et al. described this as a "lack of prioritizing of such [health communication] articles by editors and reviewers of mainstream communication journals" (p. 483). Only *Communication Education* published no health communication articles; *Journal of Applied Communication Research* published significantly more than any of the other mainstream communication journals at 24%.

Beck et al. (2004) also reported that 13% of the articles that did emphasize health communication focused on health information, 12% on campaigns, 11% on provider-patient interaction, 8% on social support, and 2% on technological issues; those were just the top categories. Combining the categories of health information, campaigns, health behaviors, and mass media yielded a total of 35%, indicating an emphasis on public health communication. Combining provider-pa-

tient interaction, social support, provider interactions, and related categories led to a total of 26% of the articles focusing on interpersonal issues. Methodologically, much variety was seen, with 26% of the articles that identified data collection and analysis methods in the abstracts reporting qualitative interviews, 23% utilizing self-report data, and only 8% using artificial scenarios.

An examination of the studies that looked at data from actual health care participants indicated that 68% of them "prioritized actual experiences and reactions" (Beck et al., 2004, p. 485). Looking at methods of data analysis, 55% of the articles used thematic analysis and 27% used multivariate analysis. Rhetorical analysis was used in 10% of the articles, content analysis in 7%, and conversation and meta-analysis in less than 1% each (although we've since published a few more conversation analytic pieces). Seventy-seven percent of the health communication articles did not indicate a theoretical orientation in the abstract, but grounded theory was most common in those that did indicate a theoretical framework.

A related analysis was undertaken by Parrott (2004), although Parrott focused on a categorization of health communication work based on multiple discourses. Parrott concluded that "the published health communication research in ICA (International Communication Association) and NCA (National Communication Association) journals makes evident that a strong knowledge base has been accumulated in efforts to address the role of communication for naming and explaining health status" (p. 767). Parrott's assessment of health communicative phenomena is broader than that used by Beck et al. (2004), leading to her assessment of a stronger knowledge base, but both scholars present a view of health communication that is highly consistent with a public health perspective. Both articles also offer numerous helpful suggestions for future research directions for the field.

TRENDS

Although, as Bill Evans's bibliographies and categorization indicate, research on provider-patient interaction has always been an important area within health communication, we've seen some changes in such work in recent years. The research has generally moved away from a focus on the provider as the heart of the dyad and the implied cause of communicative problems. Just as was advocated many years ago (Sharf & Street, 1997; Thompson, 1984), more and more provider-patient interaction work takes a dyadic focus than was the case in the past. Even the work that isn't really dyadic in its unit of analysis is less likely to imply that blame for communication problems lies with the care provider.

Another interesting and important trend has emerged in the past few years as health communication and public health scholars have come closer together in terms of perspectives and the type of work conducted. In the early years of the journal, public health and health communication perspectives

were rather different. There are still some differences between them, but people like Jude McDivitt and Becky Cline, among many others, have helped bridge that gap. We see more complementarity between the perspectives, which is quite healthy. We see such scholars working together and building on each other's research.

As a part of this, we see much more focus on health outside of the medical context and outside of planned intervention efforts in work published today. This has long been advocated by public health scholars studying health communication (see Rootman & Hershfield, 1994), and is now being actualized in the work of such scholars as Becky Cline. Cline's (2003) chapter in the *Handbook of Health Communication* focuses on everyday talk as part of health communication. As most of us spend much more time in everyday talk than we do in medical interaction or experiencing deliberate health intervention efforts, it is likely that this direction for research is a fruitful one. Cline and others are continuing to build work in this area.

An examination of the articles that have recently been accepted for *Health Communication* (or that are close to being accepted) but not yet published provides an interesting view on directions in which research in the area is going. Many of these articles tend to be international in scope. We find several focusing on entertainment and education television programming and its effects. A few are practical assessments of campaigns, interventions, or of training or assessment programs for care providers or patients. There's research on cigarette warning labels and on fear appeals. There's lots on health information-seeking. One article asks if physician-patient e-mail can be patient-centered. A couple of articles take dialectical perspectives on health communication issues or focus on normative social behavior. Direct-to-consumer (DTC) ads are a big topic; indeed, DTC and Web-based communication are the biggest topics in health media issues now. We have some research coming out focusing on holistic health issues, body satisfaction concerns, and stigmatization of health problems. Work discusses concerns relevant to medical interpreters, the elderly, antismoking messages and smoking images, controllability attributions of such issues as obesity, water conservation, online participation, organ donation, nutrition risk communication, diagnosis of Down syndrome, breastfeeding images, and dialysis care. Several studies focus on the important topic of binge drinking and curtailing it. One particular favorite of mine (accepted without even going through revision!) examines human affection exchange and neuroendocrine stress recovery. Yet other work takes a critical and cultural approach to health campaigns or looks at a plain language Web site for parents of deaf children—a decidedly practical topic. We have studies that look at social support after 9/11, colorectal cancer screening, pro-eating disorder Web sites, social capital, risk assessment as it relates to perceived similarity, interactive safer-sex Web sites, drug resistance strategies, recall of antidrug public service announcements, media literacy and smoking in adoles-

cents, SARS (Severe Acute Respiratory Syndrome) in the media, telemedicine, patient participation and physician information provision, affective orientation and eating behavior, breast cancer risk estimates, wording in health Internet sites, computer-based pregnancy, STD and HIV prevention, communication about race and health, communication issues relevant to federal government safety regulations, counseling sessions in stroke physiotherapy, and metaphors in stroke recovery, among others. Wow! What an exciting array of research awaits us.

SOME UNDERREPRESENTED TOPICS

In addition to less work than I would like to see focusing on theory development, there are several other areas that I would like to see more work on, in the journal in particular and in the field as a whole. I'd like to see more discussion of communication about medications, particularly about the side effects of medications. I'd like more work on end-of-life issues, as many of the key considerations related to those are fundamentally communication concerns. I'd also like more focus on communication as it relates to genetics and genetic testing. It would be helpful to receive more submissions on health communication education and training concerns.

In general, I'd like to see more work that looks at actual talk and examines language issues. I think that some of the conversation analytic work we've published is most interesting. More on metaphor would be fascinating. And I loved Alan DeSantis's (2002) ethnography of a cigar shop. Such qualitative work makes important contributions to our understanding of how real-world health communication processes work. More work on eating disorders as they relate to communication concerns would be welcomed, as would more on religion and spirituality as they interrelate with health communication. We could use much more examination of health outcomes. We've begun to see a fair amount of work on DTC drug advertisements and their consequences—this is certainly an area that could benefit from more growth. I'd like more on factors related to empathy and how it affects communication, as well as more on alternative and complementary medicine.

We have occasionally seen health communication research that relates to health policy issues—policy work would be much welcomed, as well. Many health policy issues have as fundamental concerns communicative considerations. On a related note, wouldn't it be interesting to look at all the health communication issues that arose as a result of the Medicare Part D initiative that took effect last January?

REVIEWING

Now for a unilateral topic change with no effective transition of which I can think. There are several things I'd like

to say about reviewing and reviewers at this juncture of my editorship. First, I'd like to offer a huge thanks to the members of the editorial board and the large number of other individuals who have reviewed for us over the years. In addition to those listed on the mastheads now and in the past, thanks go to Roger Aden, Patricia Aloise-Young, Dustin Anderson, Julie Andsager, Julie Apker, Michael Arrington, Jay Baglia, Deborah Ballard-Reisch, Smita Banerjee, Cynthia Baur, Wayne Beach, Christopher Beaudoin, Jay Bernhardt, Stephen Booth-Butterfield, Dina Borzekowski, Dawn Braithwaite, Dale Brashers, Bill Brown, Dave Buller, Brant Burlelson, Carma Bylund, Kenzie Cameron, Shelly Campo, Joe Capella, Greg Carroll, John Caughlin, Don Cegala, Fiona Chew, Mandi Chikombero, Hyunyi Cho, Youjin Choi, Elisia Cohen, Vincent Covello, Sameer Deshpande, Fran Dickson, Lew Donohew, Sharon Dunwoody, Deb Dy-sart-Gale, Nichole Egbert, Susan Eggly, Eric Eisenberg, Laura Ellingson, Bill Elwood, Matthew Farrelly, Tom Feeley, Leigh Ford, Elissa Foster, Vicki Freimuth, Kelly Fudge Albada, Walter Gantz, Howie Giles, Steve Giles, Cathy Gillotti, Daena Goldsmith, Kathryn Greene, Nurit Guttman, Stephen Haas, Jerry Hale, Nancy Grant Harrington, Tina Marie Harris, Jake Harwood, Michael Hecht, Donald Wade Helme, Lisa Henriksen, Stephen Hines, Randy Hirokawa, Robert Lance Holbert, Bob Hornik, Craig Hullett, Mary Lee Hummert, Elaine Jenks, David Johnson, Wade Kenny, Erika Kirby, Kimberly Kline, Jennifer Kopfman, Kathy Krone, Tim Kuhn, John Lammers, Maria Lapinski, Linda Lederman, Jerry Ledlow, Judith Lee, Glenn Leshner, Carolyn Lin, Isaac Lipkus, Diane Martin, Marifran Mattson, William J. McCauley, Gary Meyer, Claude Miller, Kathy Miller, Michelle Miller-Day, Jayne Morgan, Susan Morgan, Alexandra Murphy, Lisa Murray-Johnson, Amy Nathanson, Seth Noar, John Oetzel, Mark Orbe, Phil Palmgreen, Hee Sun Park, Dhaval Patel, Loretta Pecchioni, Richard Perloff, Richard Peters, Suzy Pingree, Bruce Pinkleton, Scott Poole, Brian Quick, Sandra Ragan, George Ray, Kevin Real, Ron Rice, Lance Rintamaki, Mark Robbins, Anthony Roberto, Felicia Roberts, Jeff Robinson, Ev Rogers, Alex Rothman, Kathy Rowan, Peter Salovey, Dave Seibold, Sheriane Shuler, Kami Silk, Arvind Singhal, Katherine Clegg Smith, Leslie Snyder, Lisa Sparks, Lea Stewart, Suzanne Suggs, Beverly Davenport Sypher, Karen Tracy, Jeanine Warisse Turner, Tom Valente, Melinda Villagran, Vish Vishwanath, Vince Waldron, Lynn Webb, Judith Weiner, Pam Whitten, Steve Wilson, Tom Workman, Kevin Wright, Itzhak Yanovitzky, Gust Yep, Kimo Ah Yun, Marco Yzer, Xiaoquan Zhao, Rick Zimmerman, Heather Zoller. My sincere apologies for forgetting any of the scholars who have reviewed for *Health Communication*—I'm sure that this list is incomplete. Any names that I have forgotten are merely reflections of my sieve-like memory, not the quality of the work or contributions of those scholars.

Reviewers are the key cogs in the journal publication wheel. Authors are motivated to write research because that's

what scholars do. We need it to get tenured and promoted, we need it to establish ourselves professionally, and we need it for our self-identities. Most of us do research because we love it and want to make a contribution. So authors are typically self- or intrinsically motivated. It's not difficult to get people to write articles for a journal. And an editor is assigned to a job, although editors also receive intrinsic rewards for doing that job. There's no better way to keep up on work in the field than by editing a journal. I've also been fascinated to see how my editorial work and this journal have helped shape the field of health communication. Having an outlet for publication in this area has encouraged many more scholars to do work in it. I've been able to mentor and nurture young scholars, to bring them along. It's rewarding. Reviewers, however, receive fewer such rewards. They're not working directly with authors. Reviewers are volunteers (or, more likely, solicited). They're overloaded scholars who would much rather be doing their own work, but take the time to provide feedback for other scholars. A peer-reviewed journal cannot function without peer reviewers. So I am incredibly grateful to our faithful reviewers.

That being said, however, I would also like to get on my soapbox and gently admonish those scholars who are not faithful reviewers. I feel that every scholar who publishes research has a responsibility to regularly and promptly review research as well. I know you're busy—we all are. Some people whom I've contacted about reviewing seem to think that they're busier than anyone else. It's a matter of priorities. I think that a good scholar should prioritize scholarship as a whole, not just his or her own scholarship. That means reviewing, and it means reviewing a lot more articles than you publish. If a journal like *Health Communication* accepts only 15% of the articles submitted to it, and if each submission has to be reviewed by at least two reviewers, that means a lot of people doing a lot of reviewing to put out a good journal. I'm sure that our astute readers can do the math!

I'd also like to talk a bit about the philosophy that underlies how I run this journal. I look at editing as a mentoring and nurturing process. Sometimes the submission process is just sorting the wheat from the chaff, but there are many times when, as a reviewer or editor, one can look at the role as one of helping to shape the field and young scholars within the field. For instance, are the reasons that a reviewer is rejecting a piece things that could be addressed in a revision? Is the piece written by a young scholar who perhaps hasn't received the mentoring that he or she really needs from an advisor who is too busy with his or her own scholarship or administration? Is it possible to focus on ways in which this piece can be improved, acknowledging that some flaws are indeed fatal and cannot be rectified in a revision? I've seen many reviewers reject a piece because of concerns that are not indeed fatal, issues that could be addressed in a revision. I've seen reviewers who are downright prickly in their feedback to authors, rather than being encouraging, nurturing, or mentoring. I recently had one re-

viewer refuse to review a revision of a piece (which the other reviewer had liked very much), noting that he “was never given a break and didn’t feel inclined to give others a break.” Is this how we want our field to function? I’d like to see all of us think about our roles as reviewers and the impact that we have on the field as a result of this role.

As we think about our role as reviewers, I’d also like to encourage us to be open to different approaches to research. By this I’m not referring to different research methods (although that, too, is an important concern), but to a realization that there may be different standards that could be applied when evaluating real-world health campaigns and health promotion attempts. It’s one thing to set up a well-controlled study with strong reliability and validity; it’s much harder to do that with an evaluation of a real campaign. I find that many reviewers apply the same standards to both types of efforts, and I’m not sure that such an approach takes into account the very significant problems involved in evaluating a real campaign. I think that we need to be more careful about weighing ecological validity and practical utility versus standard reliability and validity concerns. There’s a balance to be achieved, of course, but I think that our field could benefit from more rather than less real-world evaluation research.

AND NOW MOVING ON ...

All right, I’ll get off my soapbox and move on to the more important task of letting you read the articles that follow. These pieces are masterful reflections of the important work being done in the field of health communication and the directions in which our research is going. I know that you will enjoy and appreciate them. I encourage you to return to our pages again and again, as authors, readers, and reviewers. On to another 75 issues!

Teresa L. Thompson
Editor-in-Chief,
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