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Editorial

The *Journal of Health Communication: International Perspectives* Editor's Reflection—The First Decade

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Early in my academic career in Boston, I realized the need to develop premier training and scholarship in the burgeoning field of health communication. While there were academic and professional books, review chapters, professional conferences, and courses, the nascent field had a wide scope. I helped spearhead a new graduate degree program in health communication, initiating the first of its kind between a medical school and university. In 1994, the first students matriculated in the Emerson-Tufts Master's Program in Health Communication. As director, I learned first hand of the needs and aspirations of students, as well as for professional education and scholarship. In my 4 years as director, nearly 100 students had either graduated or were enrolled in the program.

At the same time, in the quest to advance the scientific and humanistic evidence base, I started the *Journal of Health Communication: International Perspectives* and became founding editor. Nearly 50 scholars joined the editorial board to support the peer-reviewed approach in academic publishing. In 10 years of editing this journal, the editorial home has moved from Boston to George Washington University's School of Public Health and Health Services. The journal has achieved many goals:

(1) The first year it was measured for impact factor by ISI (1999), it debuted as second out of 44 communication journals.
(2) It is the first journal in the field to be referenced in Medline.
(3) It is the journal of choice for public health and governmental agencies to highlight key research in health communication (e.g. supplements for UNAIDS, NCI, CDC, and others).

Rather than look back at the milestones and academic works that have appeared in the journal (this is done by expert editorial members Freimuth and Massett and managing editor Meltzer on p. 7)—54 issues, 321 articles, and more than 5,000 pages—I thought it best to offer comments on the challenges we face as we strive not only for quality in the journal, but also in our roles as health communicators.

Many frequently cite the World Health Organization's twentieth century definition of health: "A state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity." It is impossible to measure this aspiration with traditional scientific methods. Similarly, there are many definitions

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of health and communication, and even health communication, and each offer unique approaches and biases.

It may be easiest in health communication to address the field using variables of disease and supported dependent determinants/outcomes: HIV/AIDS and sexual behavior, tobacco and cancer, diet/nutrition/cholesterol, and heart disease. These miss the broader picture and potential interventions that may address the underlying issues. Ideas emerge for outcome goals that could address this knowledge gap, so that people may make more informed decisions—a baseline health literacy or broader health competency. Consumerism in health also suggests further empowerment of the patient or consumer to engage in the market for health and influence supply and demand. Yet, given the false market of "health," the patient is not a direct buyer; third party payers, policymakers, employers, and governments often reinforce the paternalistic limiting factor to attain health.

Furthermore, if we expand our goals globally to the nearly three quarters of the world's population in resource-poor settings with limited access to health care, the competing moral challenges of humanitarianism, utilitarianism, equity, and rights remain tantamount.

Absent clear leadership and societal priorities in health, we cannot attain health in the twenty-first century as we continue to stumble from development resources predominantly addressing diseases, rather than underlying economic, political, and social determinants.

Ideally, we could advocate for policies that are virtuous for those in need, distribute health products and services fairly, maximize aggregate subjective happiness, and dignify human rights.

Another challenge is how we reach our public and mobilize resources for health. The media often is cited as a vehicle and conduit of such messages. Yet, it may take a public health catastrophe to mobilize the media to muster responses and public support to invest prudently in health. Ultimately, our actions in health communication begin at home, in our communities, our schools, our workplaces, our health facilities, our academic institutions, our parliaments, and all places where decisions are made that affect our health.

Finally, my vantage point in life (and for health communication) has evolved during the editorship. I have worked in four sectors—academic, not-for-profit, government, and the private sector. My academic training continues to support my role as a doctor—now more in the original intent from the Latin *docere*—a teacher. Yet, of greatest importance is my family—my wife Katrien and two sons Alexander and Sebastian. Instilling values, imparting knowledge, advancing understanding, and sharing happiness, hope, and love are the foundations in our family. Such an elixir could be the prescription for success in furthuring health communication. It is with such ideals that I gratefully dedicate this *Journal* to my family.

The next decade of the *Journal* will further press forward ideas and add evidence for the ideal communication that ultimately preserves, promotes, and protects health amongst people throughout the globe.

Brussels, November 2005.