“a key word here is vision not just for individual people whose eyes don’t see well, but for whole communities and countries who need to look at things differently.”
— Susan Lewallen

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Our program has a unique history and we owe much to those who brought us to where we are today. We are at the end of the beginning stage in building the Emory Eye Center of the future. We have like-minded, passionate and collaborative faculty who work hard to offer the finest in patient care, teaching and education. Next, we continue to recruit the brightest and most talented collaborative physicians and researchers in the country. We are transforming the Eye Center.

How does the transformation of the Eye Center continue? We work as a team, and capitalize on many of the opportunities around us at Emory, in Atlanta, and beyond. We select unique opportunities that will allow us to distinguish our program and offer new ways to “help people see as well as they can see,” our overriding mission. In this issue, you’ll begin to see how we are expanding further outward with the Emory Global Vision Initiative (EGVI).

The Emory team is going global . . . “Global-Eyes”! We’ve recruited two leaders in international ophthalmology, visiting scholars Susan Lewallen, MD and Paul Courtright, DrPH. Both bring a wealth of experience in community ophthalmology and are now busy framing the architecture for a sustainable and meaningful international program.

Are we going global at the risk of compromising our local efforts? Absolutely not. In fact, we will enhance our local outreach. Two key issues that are important both globally and locally are: health care disparity and access to care. In fact, our program at Grady has worked nearly 130 years (since 1892) to provide care and access to care for the needy of Atlanta and Georgia. Yes, global vision includes the Atlanta community and Georgia. We anticipate that our program has the potential to be a national leader in addressing disparity and access to care issues here at home.

I look forward to the evolution of our Global Vision Initiative and engaging our team at the Emory Eye Center into the larger Emory University and the Atlanta community . . . continuing the evolution of the Eye Center!

Timothy W. Olsen
Feature | Going global
Expanding our sphere of vision
The eye? Think bigger: The globe.

By Ginger Pyron | Cover illustration by Karen Blessen

Quick: When you read the phrase “Global Vision Initiative,” what do you picture?

If you imagined a few intrepid physicians setting up U.S.-sponsored eye clinics in underdeveloped countries “somewhere over there,” you’re not alone.

That visual cliche, however, is fast disappearing, thanks to community health strategists Susan Lewallen, and Paul Courtright, who were recruited by Timothy Olsen to align new opportunities for research and education for the faculty and trainees at the Emory Eye Center. They are helping get the program off to a rolling start.

The Global Vision Initiative, its mission aligned with that of Emory’s Global Health Institute, involves far more than clinical eye care. Stretching across the vast field of ophthalmology-related service, research, and teaching, it seeks to generate operative and sustainable systems that can be implemented worldwide—not only in countries near and far, developed and developing, but right here in the underserved communities of Atlanta. From the perspective of this global health program, “the world” starts close to home.
Seeing eye to eye  In 2009 a seminal conversation took place over breakfast at the Emory Conference Center. Tim Olsen, Paul Courtright, and Danny Haddad, director of the International Trachoma Initiative (brought together through a connection with a former Emory Eye Center resident, Hunter Cherwek) talked over a multitude of possibilities and agreed on the first step toward a future Emory Global Vision Institute.

Having co-directed with Lewallen the Kilimanjaro Centre for Community Ophthalmology (KCCO) in Moshi, Tanzania, over the past decade, Courtright saw the abundant advantages of partnering with other institutions and organizations in Atlanta, such as the Rollins School of Public Health, the Centers for Disease Control, the International Trachoma Initiative, and the Carter Center.

Inspiration, opportunity, and timing worked in the Eye Center’s favor. Courtright and Lewallen, who in 2008 together received the American Academy of Ophthalmology International Blindness Prevention Award, joined the Emory faculty as visiting scholars in February 2011, committed to the initial strategizing on behalf of the Global Vision Initiative.

Seeing differently  International outreach is not new to the Emory Eye Center.

Over the past 20 years, for example, the Anderson Fellows endowment has brought a total of nine fellows from Yonsei University in Seoul, South Korea, to learn translational research from our faculty. Recently, working closely with Dr. Luz Gordillo in Peru, we participated in a study on the cost effectiveness of laser treatment for retinopathy of prematurity, in comparison to no intervention. Nancy Newman and Valérie Biousse, professors of ophthalmology and neurology, extend the educational arm of our global health program not only by training many neuro-ophthalmologists from around the world but by serving as guest lecturers and creating courses worldwide. Some of our faculty and residents have traveled independently to other countries to provide treatments and surgeries for underserved people.

But all of us still have a lot to learn about addressing the world’s vision challenges. Once Lewallen arrived, she lost no time in opening our eyes. On February 4, speaking to Emory physicians, she said, “In the developing countries, the major problem is not—as people often think—just that there are too few ophthalmologists. Rather, it’s that the available ones may lack the support, equipment, and supplies to work productively. You can have a legion of trained ophthalmologists, but without adequate management systems, blindness will remain a problem.”

Lewallen wants Emory’s ophthalmologists to understand that while the efforts of individual doctors are useful and important, those efforts alone won’t effect big changes. What matters even more, she says, is to establish ongoing programs that provide much-needed services such as training or diabetic screening.

Toward that purpose, she adds, public health professionals can be a tremendous resource of knowledge and perspective: “Once you learn to address a problem from a public health or systems approach, you start to see things in a new way and thus can make more effective choices. For example, if doctors go into a country without first finding out who else is there, unwittingly they may set up a free clinic just 10 miles away from where a local ophthalmologist is practicing, trying to make a living.”

Lewallen advises mission-minded physicians, “A more helpful strategy would include doing thorough homework before the trip, and then seeking ways to work within the area’s existing systems.”

Thinking big  “Improving global vision”: That’s a grand, even potentially grandiose, idea—one that, to become effective, requires its proponents to step way back and get a panoramic view. Two  •  CONTINUED ON PAGE 8
Taking the initiative ... downtown

Susan Primo—director of vision and optical services and associate professor of ophthalmology—has the distinction of being the only faculty member of the Emory Eye Center with a graduate degree in public health. From her dual perspective, she thinks the Global Vision Initiative is likely to take the department of ophthalmology in a very productive direction.

“As eye care specialists, we tend to focus on taking care of the eye, not always aware that the eye is just one part of the body system,” she says. “We also need to understand that good visual health influences good overall health.”

She believes that if we want to address big problems of vision, whether here at home or throughout the world, a collaborative effort is essential: “We need everybody at the table—from policy folks to health education folks to epidemiologists.”

Primo commends the approach that visiting scholars Susan Lewallen and Paul Courtright are taking toward the Global Vision Initiative—“They’re doing an incredible job of jump-starting this much-needed program for us.”—and she particularly applauds the efforts of Tim Olsen: “He doesn’t have a public health background, but he is broadening his thinking and is ready to push this initiative to the next level. I think the Global Vision Initiative will help meet some of the big challenges.”

A couple of decades back, getting her first taste of public health work while training in a community health center, Primo began to develop the passion that she still feels for the medically vulnerable population: the children, the elderly, the working poor, the uninsured and underinsured, and particularly those with unmet needs for eye care and vision care.

Later, working toward her master’s degree in public health, she began to see that undetected or untreated eye problems involve much more than the eye. “This is definitely a public health issue,” she says, “because it includes questions of access, behavior, understanding, beliefs, cultures—the whole gamut. That’s why it requires a comprehensive strategy.”

“My heart is in clinical work,” Primo acknowledges. Her clinical responsibilities—along with her own initiative—take her downtown, both to Grady Memorial Hospital, where she interacts primarily with medical residents, and to Kirkwood Family Medicine, a neighborhood health center under the auspices of the Grady Health System.

“I spend the bulk of my time at Grady sites,” she says, “because this is the type of work I enjoy most: trying to reduce the incidence or prevalence of visual impairment and visual problems.”

Primo explains that at the neighborhood center, the first task is to attempt a diagnosis, then to create access and “get people into the system”: “Once that’s done, we can help later when they develop problems related to vision loss, whether it’s something simple, such as glasses, or a potentially blinding eye disease such as cataracts and glaucoma.”

Anticipating the next phase of the Global Vision Initiative, Primo says she is eager to help: “What I hope to bring to the table is my public health background. Perhaps I can help secure some grants and funding to sustain the program as well as funnel it in directions that are most useful—not only for Georgia, but also for the world.”

To Dharamsala—Again!

Along with other Emory University scientists, the Emory Eye Center’s Michael Iuvone, Ferst Professor of Ophthalmology and director of research, returns this summer to Dharamsala, India, in the foothills of the Himalayas.

During his 10-day visit, Iuvone will continue his participation in the Robert A. Paul Emory-Tibet Science Initiative (ETSI): teaching neuroscience, via lectures and other structured activities, to a select group of Tibetan monks, who then can return to their own monasteries to share their new knowledge.

The project, now in its fourth year, has a mandate (partially from the Dalai Lama) to train Tibetan monks in the sciences. Last summer, six of the monks in the group were selected to further their studies at the Emory campus for the 2010-11 academic year.
In Peru, retinopathy of prematurity (ROP)—a disease of the retina, which causes blindness in premature infants—has been on the rise.

Through a collaborative research project, an Emory team investigated the societal burden of blindness in relation to ROP. Support for the project came from the Emory Global Vision Initiative, the Emory School of Medicine, the Rollins School of Public Health, and an unrestricted grant from Research to Prevent Blindness.

Results of the study led the team to conclude that increasing the early screening and treatment of ROP not only prevents unnecessary blindness but is significantly cost-effective for society.

For an educated adult in Peru, the mean annual income is $8,000. Thus the cost of ROP treatment for a single child is equivalent to employing 24 educated adults full-time for an entire year.

The lifetime cost savings for society for the next generation is estimated at $516 million.

Timothy W. Olsen, Eye Center director, led the 2011 study. Through Hunter Cherwek, who trained at the Emory Eye Center, and ORBIS International, a non-profit organization fighting blindness in developing countries, he became acquainted with the work of Luz Gordillo, a U.S.-trained pediatric ophthalmologist in Lima. An Emory School of Medicine third-year student, Hreem B. Dave, helped develop and execute the project, and Monica S. Zhang joined the group as translator.

“We were fortunate to have many resources,” Dave says. “Dr. Zhou Yang, from the Rollins School of Public Health, brought a very valuable perspective. Her PhD is in health economics, and she helped us figure out how to approach the study in a way that’s logical from a health economics point of view.”

The study and its data, Dave explains, can provide useful guidance for decision makers in Peru: “This economic data, combined with our medical knowledge about the natural history of ROP, will be important to present to health care ministers in Lima. It will help them make appropriate decisions on how to allocate their resources in the future.”

During a weeklong trip to Lima, the group accumulated data, observed the day-to-day clinical work of Gordillo, investigated the support systems available for a blind person in Peru, and determined the resources needed.

“Here, we know what we would need to treat someone who has ROP, and those resources are available,” Dave observes. “But what if you’re working in a rural area without electricity? Instead of taking exactly what we do here and trying to plop it into another country, we have to figure out how it can work there, and how much it will cost.”

Public health, she explains, analyzes local situations and puts them in a cultural context, “so that our work can have the impact that we’re intending. We have to make contact with doctors there who know how to work the system and have been able to deal with minimal resources.”

Dave says with admiration, “Dr. Gordillo’s role in this project cannot be overestimated. She has been the MD equivalent of a Florence Nightingale, addressing this public health issue in her home country of Peru and do-

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**Facts from the team’s cost-analysis (in USD):**

- Estimated total indirect cost to the country, for each Peruvian child with neonatal blindness related to ROP: $197,753
- Total direct cost to Peru, for ROP-related laser treatment of just one child: $2,496
- Amount that Peru can save, over the lifetime of each affected child, by using the laser treatment: $195,257
ing work that sets the stage for other middle-income countries around the globe.”

On May 3, 2011, at the annual meeting of the Association for Research in Vision and Ophthalmology (ARVO), the team presented its study, “The Societal Burden of Blindness Secondary to Retinopathy of Prematurity in Lima, Peru.” The Emory team is hoping to see the study published in a medical journal, so that Gordillo can use it as a resource when she meets with Peruvian ministers of health.

After her May graduation from Emory, Dave begins her residency at Rush University in Chicago. As Dave moves on, another third-year medical student, Christopher Williams, will be taking over the project. He plans to investigate the importance of systemic therapy and neonatal oxygen therapy to lower the burden of ROP in middle-income countries. “I’d like to keep doing international projects, helping make health care available to everyone,” Dave says. “But I also know it’s important to do that work here.” She has been a frequent volunteer with Student Sight Savers, doing glaucoma screenings at Atlanta health fairs and churches.

Like many who have seen enormous health care needs firsthand, Dave focuses on positive results. “One of the biggest things we realized in doing the ROP study,” she concludes, “is that something small can make a huge difference. If laser treatment can save the vision of only four out of ten children in Peru who are at risk for ROP, that means four children can grow up to be adults and will have a much better quality of life.”

**Research by the community, for the community**

“Right now, we’re still just planting the seeds,” says international ophthalmologist Susan Lewallen.

Along with confirmed or potential partners—the Lions Lighthouse, Prevent Blindness Georgia, some student groups, and some community groups around the city—she’s envisioning a network that can start changing the future of Atlanta’s vision-related public health right away.

**In this endeavor, the first and most important word is together.** Once people from these interested groups meet around the same table, they can begin investigating the vision issues in Atlanta that they themselves, from firsthand experience, consider top priority. Formed to conduct what’s called “community-based, participatory research,” the network frames questions that will determine their next steps: What do we already know about vision care needs here? What other questions should we be asking? How do we capture the full story of vision-related problems, from diagnosis and access to treatment and follow-up?

“The community groups help determine the priorities and pose the questions,” Lewallen emphasizes. “For example, maybe they will decide to talk with community people who’ve gone blind from glaucoma or diabetic retinopathy and to document their journey of care. What barriers did those people encounter when seeking out medical help? What situations—perhaps beyond the patients’ control—added to their struggle?”

From grass-roots concerns and through grass-roots inquiry, the larger network of community partners can learn what needs doing first. Then the coordinators of the project can draw on the network’s resources of funds, people, and ideas to set up health education activities and screenings that help address problems of access to vision care.

At this point, the details are still taking shape. “The project doesn’t even have a name yet,” Lewallen says. She’s aware of enthusiasm for the idea among several people at the Emory Eye Center, including Annette Giangiacomo, assistant professor of glaucoma, and Susan Primo, associate professor of ophthalmology.

“These two doctors share a keen interest in glaucoma, which is one of the major causes of blindness in Atlanta’s underserved population,” she says. “And Primo has a master’s degree in public health, plus a lot of experience in the communities.”

In keeping with Lewallen’s tried-and-true principles for all new public health programs, the prospective “community-based, participatory research network” will start small, plan carefully, seek funding, take on a project or two as a group, and then see how its efforts can grow.

With her usual optimism, Lewallen shares her own vision: “I’m looking at this project as the kernel that might eventually become the thriving Atlanta branch of the Global Vision Initiative.”
big, related topics that inform Olsen’s thinking about the initiative’s future are disparity and access.

“We know a great deal about how to treat eye diseases,” he observes, “but in health care worldwide, disparity—a widening gap in either information or financial resources—is a serious problem. I hope that the Global Vision Initiative can help reduce the knowledge gaps through education.”

Courtright explains that the problem of health care access is complex—and growing: “To achieve some level of equity, we don’t have to sacrifice the quality of care. But we do have to ensure that people in need of services are in a position to access them. This issue is being faced everywhere in the world, and it’s going to be faced here in America.”

Partnerships with other aspects of medicine, with public health, and with community groups such as the Lions Lighthouse and Prevent Blindness Georgia he says, are essential to eye care’s survival and growth.

Thinking big—and bigger—about global vision can also involve remembering that major challenges exist here as well as there. “When I talk with friends of the Eye Center about global vision projects that we could pursue in Africa, South America, and Latin America,” Olsen says, “someone always brings up local conditions: What about the health care disparity right here in Atlanta? or You know, Grady Hospital is also on the globe.”

To Lewallen, that point is crucial. “I came here thinking that the biggest need was overseas, but now, having visited Grady Memorial Hospital and having talked with both Prevent Blindness Georgia and the Georgia Lions Lighthouse—the two main community groups trying to provide eye care for patients who don’t have insurance—I see that conditions here in Atlanta are just as urgent. And they may be more important to people here than overseas issues are. I imagine that Emory’s Global Vision Initiative is going to be just as active in Atlanta and Georgia as in other countries.”

In Atlanta as in Moshi, Tanzania, the problem of access includes a range of limitations: Many people lack the means to pay. People needing eye care my not know where to go for help, or may have difficulty getting there. Someone who has a job may be unable to take time off for a medical appointment.

“Follow-up care after a diagnosis poses another big challenge,” Lewallen adds, “and in some ways it’s an even bigger problem here than in Africa. Locally there’s a huge population that’s not served. For example, if doctors at a free community clinic find that a patient without insurance needs surgery, they may have to scramble to find a place where that person can be operated on.

In Africa, our work with the KCCO has resolved that complication; we run our outreach clinics from a base hospital, where we can perform surgery as needed.”

Since most U.S. ophthalmologists work in medical clinics—where patients come to them—they may not encounter problems of disparity and access, may not think about all the systems that must be in place before an ophthalmologist can see patients and save vision. “But as physicians,” Lewallen states, “we have a responsibility to think about those things. We need to help make eye care possible for people.”

One physician who takes that responsibility seriously is the Eye Center’s Geoff Broocker, Walthour-DeLaPerriere Professor of Ophthalmology and chief of service at Grady Memorial Hospital. For the past 23 years he not only has trained hundreds of Emory medical residents but has treated countless patients who need treatment they cannot pay for.

He’s also a tireless advocate for this increasingly at-risk population. “For the first time in my professional career,” Broocker says, “I’m taking care of patients who cannot get their medications or their surgery. Social workers are telling me that outside funds are drying up, going nonexistent. At Grady, too, resources are limited. How are these people going to get access to care? And
these problems are just the tip of the iceberg for what I think we can extrapolate to health care across the U.S. in the next 10 to 5 years.”

According to Lewallen, there’s still some good news: “Like Dr. Broocker, a lot of concerned ophthalmologists are looking at the local issues and are really concerned about them. I admire those people; they have opened my eyes.”

Courtright adds, “Global means the whole picture, and there’s learning to be done on all sides of it. What people from the Emory Eye Center and its partners can figure out within the setting of Atlanta will help provide solutions to issues in other countries. And vice versa: When we learn how people deliver services in settings beyond the U.S., we need to consider what those methods can offer us here.”

Starting small  Six months of laying groundwork, of course, isn’t going to result immediately in a $10-million grant from the National Institutes of Health, or a plan for solving the cataract problem for the continent of Africa, or an internationally renowned Global Vision Institute. All three members of the core strategic team—Olsen, Lewallen, and Courtright—agree on that.

They also agree on the two most useful ways to spend these months: taking some thoughtful small steps and developing the vision. “We have to start small,” Olsen says. “Before we can look for any major funding, we need to prove that we have the people and the expertise to carry this program through.”

Plans for this phase of the initiative include some of the methods that Lewallen and Courtright routinely employ for setting up community ophthalmology programs in eastern Africa:

1) Identify the stakeholders—as many as possible.

For the Global Vision Initiative, this

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Translational—and transnational

Translational research: integrating the latest thinking and results in vision research with clinical education and treatments. At the Emory Eye Center, that’s a point of emphasis. And for two decades, thanks to the Anderson Fellowship program, we’ve had the privilege of sharing it with clinicians and scientists from Korea.

Paul Anderson Sr. (’38C-’40L) established the fellowship in 1987 to honor his father, Earl Wills Anderson (1901C), a medical missionary who was instrumental in helping to found one of Korea’s first ophthalmology departments, at Severance Hospital and the medical school now affiliated with Yonsei University in Seoul. The endowment supports approximately a year of study for one Yonsei fellow at the Eye Center every two years.

The longstanding alliance between the Emory Eye Center and Yonsei University has provided for the valuable exchange of skills between countries. The first Anderson Fellow, Eung Kwan Kim (affectionately known as “E.K.”), is now a world-renowned professor who specializes in cornea and refractive surgery at Yonsei University. His fellowship at Emory was under the direction of Henry F. Edelhauser, the Eye Center’s director of research at the time.

And the connections continue. Kim’s daughter, Woon Cho Kim, is a currently enrolled medical student at the Emory School of Medicine. Not surprisingly, a career in international medicine is among her aspirations.
Global views on pediatric cataracts

In March, the Emory Eye Center hosted an International Congenital Cataract Symposium in New York City, where pediatric ophthalmologists and epidemiologists from Egypt, Tanzania, Bangladesh, India and England discussed the global need to provide surgery for children who have a cataract, now the leading cause of childhood blindness in many developing countries.

The meeting—supported by funding from industry sponsors, the Georgia Knights Templar Educational Foundation Inc., the March of Dimes, and the von Habsburg Foundation—brought together knowledge and data from around the world, perhaps lessening current disparities in health care.

Directing the event were Emory Eye Center’s Scott R. Lambert, R. Howard Dobbs Professor of Ophthalmology and Pediatrics; Edward Cotlier, a research scientist at New York State Institute for Basic Research in Developmental Disabilities; and David Taylor, professor emeritus, University of London.

Lambert is the national study chair for the National Institute of Health’s Infant Aphakia Treatment Study (IATS), covered in our last issue of Emory Eye—a multi-year, multi-clinic study to determine whether an intraocular lens (IOL) or a contact lens is the best treatment for optimal vision in young children, following removal of the cataract.

The list comprises all the potential partner institutions and organizations that the visiting scholars already have begun contacting.

3) Establish strong links between the Eye Center and the Rollins School of Public Health.

The RSPH has been an obvious place to start. Overlapping areas of interest exist between the Global Vision Initiative and all six of the school’s departments, making these two entities natural partners. “We’ve had a uniformly enthusiastic reception at the Rollins School,” says Lewallen.

4) Cast a wide net for advocates.

“At this stage,” says Courtright, “We’re trying to cast the net as wide as possible. A strength of Emory—and of Atlanta, as an international city—is the number of local organizations, groups, and even businesses that are involved in global issues and that, along with the Eye Center, can be influential advocates for meeting these needs.”

5) Seek small successes; build gradually.

According to Lewallen, “To build a meaningful, sustainable institution, you start with small, feasible projects, endeavors in which you can have successes—and take your time working up toward more ambitious efforts.”

She sums up this initial phase as “a great opportunity for us to make vision not only the focus of this initiative, but also the way we go about our work.”

Looking ahead

Starting small, however, doesn’t mean putting big dreams on hold. “Long-term, we’re envisioning a transformation of the Emory Eye Center, but right now we’re still in the early phase of design,” Olsen explains. “Like architects, we’re sketching out the different parts of this initiative, considering where they need to be placed, and making creative decisions based on the best use of our resources.”

At July’s end, when the visiting scholars’ initial six-month visit is over, what progress can we expect to see?

Olsen has answers: “I think that we will have explored and formalized the opportunities here. And by July, we also may have begun to apply for some small start-up grants, to get seed money for early-phase projects.”

A similar outlook comes from Courtright: “Yes, I think we have the opportunity to get some small grants that will bring the School of Public Health and the Emory Eye Center together on some issues regarding Atlanta—as well as identifying some ophthalmologists who have an interest in international is-
issues and might want to join either Susan or me in some of our ongoing work. We can create ties that can be expanded later, in terms of further grants, additional research, and training programs. And I hope that after six months we will have developed some concrete grants or programs that people can join or support. We have to build piece by piece, choosing the activities that are most desired and practical both for the Eye Center and for the global health program.”

And finally, there’s an all-important question: Who will lead Emory’s Global Vision Initiative?

With luck, that question, too, will be resolved during this time period. To Olsen, “Recruiting a leader is one of the main goals of this initiation phase. We need to set the architecture of this program, then bring in a leader who can take it over and make it what she or he believes will become one of the most effective programs in the country at organizing and addressing these priorities.”

“That’s one of our primary challenges,” Lewallen adds, “because leading this program requires an unusual mix of skills. It’s going to need someone who’s completely dedicated.”

New relationships, new hope  Jeffrey P. Koplan, director of the Global Health Institute and Emory’s vice president for global health, affirms the team’s preliminary work:

“In the immense field expertise of Drs. Courtright and Lewallen, we have a real treasure. Tim Olsen’s leadership is perfect: He’s seeking areas in eye health that make sense for his department and his staff of professionals, students, and trainees. And he’s looking at multiple ways to put his ideas into place. With these assets in addition to our already very strong, academically gifted ophthalmology department, the Global Vision Initiative ought to go very well. It’s the right thing to do, and it’s a highly productive thing to do.”

In the future, Koplan hopes to see relationships established across the university, creating new links between people who seek answers about eye disease. He also envisions an increasing number of opportunities for residents and fellows to help create programs in developing countries. “My other hope and expectation,” he says, “is that five or ten years from now, robust relationships will exist between Emory’s department of ophthalmology and several hospitals and universities around the globe.”

At the everyday level of right here, right now, there’s also the hope expressed by Geoff Broocker: “We need to heighten the awareness of people in our own country about what’s happening here—the local situations that mirror global ones and that may escalate until they equal the crisis of health care access elsewhere in the world. If the public health approach can solve vision problems in Tanzania, maybe it can solve similar problems in Atlanta.”

About the work of this six-month period, Broocker says: “I’m excited, because Dr. Lewallen may open a window for change. People are listening.”

Molecular Vision – from West to East

Since 1995, a remarkable pipeline of scientific information related to molecular biology, cell biology, and the genetics of the visual system has been pouring into the Emory Eye Center and, after review and approval, has been pouring back out into the scientific world at large.

This conduit—the award-winning, one-of-a-kind, peer reviewed online journal Molecular Vision—is the brainchild of three Eye Center faculty: Jeffrey H. Boatright, Robert L. Church, and John M. Nickerson. A highly successful open-source public journal (no cost to anyone with internet access), it offers a novel means of addressing financial and coverage disparity in the publishing and transference of knowledge. And it ranks in the top 15 percent of all scientific journals in either hard copy or online.

Up until now, the bulk of financial responsibility for the electronic journal has fallen on the Eye Center. Great news in the lab and elsewhere, however, is that the situation has changed.

With deep appreciation, we announce that Molecular Vision is now jointly sponsored by our partners at Zhongshan Ophthalmic Center, Sun Yat-sen University, P.R. China.