
Guest Editor's Page

The very reason that this special supplement of the *Journal of Visual Impairment & Blindness (JVIB)* on public health and vision loss is so important also makes it risky. Let me explain. This volume is important because for too long, the overlapping fields of public health and vision-related rehabilitation and special education have not been in communication with each other. This has been a loss to consumers of their services who do not carve up their goals, rights, and needs to correspond to professionals' definitions of specialized expertise. Service providers must cut through the walls that divide them to fulfill their broadest aims of service. The intent of this supplement is to begin the needed dialogue.

But the risk is clear. Conversation among persons with different backgrounds can be fraught with misunderstandings. Certainly, the backgrounds of professionals in the field of public health (which includes more than 50 occupations) and professionals in the field of visual impairment differ. Not only has their training covered different specific content, but, more subtly, it has stemmed from different perspectives on community-level versus individual-level outcomes. After training, these professionals' work settings differ in a significant way: the relative dominance of biomedical versus nonmedical activities and orientation. At the policy level, the legislation and governmental agencies with which professionals from these fields are most familiar also differ. In the remainder of this editorial, I touch on the sources of the hazards of communication in this supplement and introduce the articles that the supplement contains.

One hazard is terminology, especially as it pertains to relationships with consumers, as is illustrated in Duane Geruschat's editorial for this supplement. A more basic hazard stems

from the concern of the field of visual impairment that an emphasis on health means committing to a "medical model." The term *medical model* is negatively charged for different reasons. For vision professionals, it refers to specialists who work under a medical aegis, notably occupational therapists, who may conduct vision-related rehabilitation in competition with vision rehabilitation therapists who are trained and certified outside the medical arena. For others, especially consumers and disability policy analysts, the term means that the societal disadvantages experienced by people with disabilities is attributed to their medical condition (as in the idea that a person cannot work because he or she is blind), rather than to the attitudinal and other barriers that people with disabilities encounter that are in violation of their civil and human rights.

The introductory article, by Crews, Kirchner, and Lollar, orients readers to these views as they approach the new crossroads of the fields of public health and visual impairment. That article and sections of my subsequent article offer insights into the nature and reasons for the past gap between the two fields and point to a collaborative way forward.

A comment on the broader policy environment for such collaboration is needed here. The United States, with its poorly coordinated health delivery system and fragmented disability policy, is hardly conducive to offering a clear roadmap for going forward in this supplement. Indeed, although one aim of public health is to promote a more rational health policy, the field itself is scattered through many organizational structures whose relationships are not crystal clear.

Consequently, for example, an administrator or consumer advocate in vision rehabilitation, who is motivated by having read the article by DiStefano, Huebner, Garber, and Smith on using the community-based public health approach to serving persons who are visually impaired, faces an organizational maze. The web portal <www.health.gov> provides

helpful links to the numerous federal agencies that have health-related programs. But the determined user still needs to research the best match between a funding proposal or advocacy message that promotes healthful lifestyles and community environments for people with visual impairments and one of these agencies.

One avenue for matching proposals for vision rehabilitation initiatives with public health policy and programs is proposed in my article, in which I explain the most relevant parts of a public health policy initiative (called Healthy People 2010) as a potentially unifying framework for collaboration. But I also point out the limitations of the framework, notably an overabundance of specific goals. This mixed picture—opportunities to leverage the emerging public health interest in visual impairments and barriers to following through—is a persistent thread in this supplement.

The idea of a mixed picture stood out when I looked through the December 2006 issue of the *American Journal of Public Health (AJPH)*. By coincidence, the issue's theme, "Embracing a Common Destiny: Health for All," resonates with the aim of this supplement to *JVIB*. A couple of *AJPH*'s articles echo and expand the topics of articles in this issue. This coincidence is satisfying, since it offers *JVIB* readers a resource to pursue the ideas that are raised in this supplement. Why, then, do I consider it provocative?

The coincidence is provocative because the *AJPH* theme raises a question: How, in that collection of articles labeled pursuing "health for all," does health for people with disabilities emerge? The answer is that basically, it does not. There is no mention of people with disabilities in a lengthy editorial on disparities in health status among subgroups of the population (Koop, 2006) or in a commentary on the need to diversify the health workforce (Mitchell & Lassiter, 2006).

But the problem is not just one of omission. Only 1 "research and practice" article out of 19 in the December 2006 issue of *AJPH* concerns a disability-related matter (Khoshnood et al.,

2006). The topic, expanding prenatal testing for Down syndrome, exemplifies the caution with which disability rights advocates view public health approaches to disability. Similarly, a physician, writing in the Science section of *The New York Times*, focused on prenatal testing for deafness or dwarfism, characteristics that some potential parents with these conditions value for their cultural, rather than medical, meanings (Sanghavi, 2006). These examples trigger the underlying ethical and often emotional concerns mentioned earlier about the medical model in relation to human rights. The concern is whether health professionals approach disability seeking *only* to prevent disabilities, especially when a prenatal diagnosis can lead to the prevention of *people* with disabilities, rather than working to maximize the conditions that people with disabilities need to lead physically and socially active lives in good health.

Fortunately, as the 2005 report of the Surgeon General (U.S. Department of Health & Human Services, 2005) made explicit, public health planners and practitioners increasingly understand their role as collaborating to avoid secondary disabilities and to promote health, fitness, and an overall good quality of life for people with disabilities. In this supplement, the article by DiStefano, Huebner, Garber, and Smith, mentioned earlier, challenges and, we hope, will motivate service providers to integrate their aims and information across disciplines in order to serve people with visual impairments holistically.

The article by Hendershot, Placek, and Goodman describes a conceptual model that incorporates the medical and nonmedical aspects of visual impairment and thus facilitates communication between the fields of public health and visual impairment in the process of measuring the need for and outcomes of services. Crews, Jones, and Kim's article stands out in this collection as an example of empirical quantitative research. It illustrates the fruits of the sought-for dialogue between the fields by examining measures of biomedical

(continued on p. 779)

John E. Crews, DPA, lead scientist, Disability and Health Program, National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention, 1600 Clifton Road NE, Mail Stop E88, Atlanta, GA 30333; e-mail: jcrews@cdc.gov. **Corinne Kirchner, Ph.D.**, senior research scientist, Policy Research Department, American Foundation for the Blind, 11 Penn Plaza, Suite 300, New York, NY 10001; e-mail: [corinne@afb.net](mailto:<corinne@afb.net>). **Donald J. Lollar, Ed.D.**, acting director, Office of Extramural Research, National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention; e-mail: dlollar@cdc.gov.

Guest Editor's Page

(continued from p. 772)

conditions, health as a self-assessed experience, and functional abilities among elderly persons who are visually impaired that are to be addressed by the rehabilitation and accessible communities. We expect to see much more empirical research—both quantitative and qualitative research—that will include measures of environmental access that affect health and social participation.

Janiszewski's article illustrates and promotes effective public education about vision loss. It shows that public awareness is a vital component of improving eye health for preventable conditions and of general health for persons who are visually impaired through vision rehabilitation. Notably, it emphasizes the importance of the ongoing evaluation of program outcomes.

Finally, a Roundup of short pieces should tantalize the reader who is enthused about the possibilities that public health offers to serve people with visual impairments more holistically. Because of space constraints, we cover only a sample of relevant programs, and only highlights of each. Rimmer discusses opportunities for physical activity; Sapolin addresses emergency preparedness; Ponchilla reports

on diabetes management; Horowitz and Reinhardt shift to the systems level, focusing on the mental health system; Orr, Rogers, and Scott turn our attention to the aging network; and Topor puts the spotlight on the Indian health system.

In closing, I have a sense of satisfaction, having worked for months with so many dedicated authors and with staff members of AFB Press and the Office of Disability and Health of the Centers for Disease Control and Prevention to arrive at this diversified supplement to *JVIB*. But the notion of a mixed picture pops up again. I am only too aware of how much we had to leave out. Now it is your turn to read, discuss, explore, and start writing to carry the thread forward in future regular issues of *JVIB*.

REFERENCES

- Khoshnood, B., De Vigan, C., Vodovar, V., Breart, G., Goffinet, F., & Blondel, B. (2006). Advances in medical technology and creation of disparities: The case of Down syndrome. *American Journal of Public Health, 96*, 2139–2144.
- Koop, C. E. (2006). Health and health care for the 21st century: For all the people. *American Journal of Public Health, 96*, 2090–2092.
- Mitchell, D. A., & Lassiter, S. L. (2006). Addressing health care disparities and increasing workforce diversity: The next step for the dental, medical and public health professions. *American Journal of Public Health, 96*, 2093–2097.
- Sanghavi, D. (2006, December 5). Wanting babies like themselves, some parents choose genetic defects. *New York Times*, F5, F8.
- U.S. Department of Health and Human Services. (2005). *The Surgeon General's call to action to improve the health and wellness of people with disabilities*. Washington, DC: U.S. Department of Health & Human Services, Office of the Surgeon General. Available at www.surgeongeneral.gov/library/disabilities/calltoaction/calltoaction.pdf

CORINNE KIRCHNER, PH.D.
GUEST EDITOR