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It is a signal honour for me to be asked to address you in this great state of Singapore as there is an old and deep bound between me and Singapore. I had both my undergraduate and ophthalmic training here and I have so many dear friends and colleagues. May I single out my teachers, the late Mr Williamson and Dr Wong Kin Yip and there are so many other friends and colleagues. It is delightful for me to have witnessed the opening ceremony and listen to the address Dr Kwa Soon Bee and to say how proud I am to see an old friend and colleague as Permanent Secretary and Director of Medical Services, Singapore.

Being given the privilege of choosing the subject for this address, permit me to make a few remarks on our role as professionals in our communities more specifically and our ophthalmic role as guardians of vision. What is the image we have projected to society and what society thinks of us.

Professional Man
Throughout the world the ambition has been and still is to become a professional; to be a doctor, lawyer, accountant, engineer or a member of the whole range of other professions. The professional is indeed an admired individual as one who is there to solve the problems of his community. He enjoys good social status, is respected for his special knowledge and skills, and earns a good income.

The past two decades has seen the professional getting into increasing troubled. This criticism of the professional is world-wide with each country having its share. In the USA malpractice suits have shaken the very foundations of professions and what they stand for. The lawyers, the filters of these suits, have not benefited either and American society is becoming increasingly disenchanted with them. The recent Bhopal tragedy is a glaring example of some professional captialising on human misery. We the doctors who were once thought to be on the border of the divine have had a sharp decline in respect. Here at home it is not uncommon to read criticisms of the professional including doctors, particularly the medical specialists.

Accelerating Specialization
The second half of the twentieth century has been an era of accelerating change for the professional. The scientific revolution which has gained momentum in the past decade has led to increasing specialization to master new and complex knowledge. The results are multiplication of branches (specialization) in each 'major' profession. The professional today looks towards becoming a specialist rather than remain as a generalist. Having reached specialist status he feels he is 'superior' to his colleague who practices a wider span of medical knowledge. As specialization increases we learn more and more about less and less. An ophthalmologist may spend most of his time dealing with cornea or glaucoma cataracts, retina, neuro-ophthalmology or any of the other sub-specialities and the list is long. We have to remind ourselves constantly that the eye is part of the human body. This narrow specialization makes it difficult for the professional becomes more an individualist having his idiosyncrases and giving preferences to his own narrow interests. The most common cause of poor vision e.g. a refractive error does not interest him and must be left to his most junior assistant to be sorted out.

Ethics
Professionals take pride that they have a self-imposed code of ethics which is for the protection of their community.

Because of the ever increasing range of services provided, abuses of ethical codes are increasing. These abuses involve professional fees regulations, mal-practices such as fees splitting, ambulance chasing, sale of certificates, medico-legal collaborations, soliciting of patients, cocktail parties and opening ceremonies, heavy window dressing of practices to impress the rich, advertising, etc occur and further tarnish the professional image. Specialists in the public sector who highlight these

breaches of ethical conduct succumb and commit the same abuses when they move into the private sector.

Rising cost of Medical Services
Perhaps the most common and frequent criticisim of the professional is related to the increasing costs of providing professional services both in terms of money and time. To some extent this is inevitable in this era of changing technology, of rapid progress and sophistication. The professional has, at least in terms of the ideal, conveyed the impression to the community, that he is service orientated. The profit motive is not his primary objective though for his professional service he is entitled to and must be paid a fair remuneration. The high cost of current specialist care does not reflect this ideal.

The 'Time' magazine in a feature article on "Medical Miracles" ended by posing the question "but how to pay the medical bill?" and this is the USA the richest developed country. The prime minister of Malaysia, Dr Mahatier, a doctor himself when opening the International Medical Meeting September 1986, asked whether Malaysia can afford the cost of modern medical technology and said we should have more efficient ways of spending health funds. Specialists and surgery are costly he said and cutting costs must receive serious attention. He suggested we consider mass surgery to cut costs but in doing this we retain the personal relationship between patient and his doctor. He stressed that doctors learn how to cut costs as the poor must not be deprived of adequate medical attention.

At the last sitting of Malaysia's parliament the Minister of Health said government was considering the regulation of fees charges by private hospitals and would be recommending fee scales. The consumers association in recent articles in the press went much further saying private hospitals and their specialists were charging "super-high" fees and asked for legislation to lay down maximum permissable fees.

Custodians of Vision
Permit me now to make a few remarks. On our role as guardians of vision in our community, I begin by quoting Prof Barrie R Jones on the great responsibility on ophthalmologists. He says that as ophthalmologists we are the repository of knowledge of the eye and of the skills for the cure of its diseases. We are also, he continued, seen as the custodians of the eyes of the people, the people in health and the people under the threat of blinding severity of disease, be they in our clinics, in our city slums or in our remote villages or kampung. He asked who will seriously take up the challenge, who will devote himself (with full professional, academic and practical energy) to the plight of those who are going down the pathways of needles blindness and there are more than 20 million of them in this world.

For if we, who know about the eye, do nothing to ensure effective and wide spread promotion of the eye health, or to ensure the widespread preventive application of simple treatment in the homes or to ensure we reach the mass of the blind that live beyond the reach of curative surgery that is locked up in our great and precious hospital centres; if we the custodians of their eyes fail who then will reach them. Who will reach them in their triple need for eye health promotion, preventive care and curative treatment."

Prof Jones message is loud and clear. We are indeed the custodians of the eyes of our communities. We the ophthalmologists must necessarily play the central and key role in community eye health programmes which must relate to the socio-economic and other conditions of the communities we serve.

Ophthalmology, a major speciality
To do so effectively we must ensure the status of ophthalmology as a branch of medicine is no longer regarded as a minor medical speciality. As a speciality, equal to any other, it must have equal chances of receiving essentials such as financial and technical support for adequate community eye care programmes. Permit me here to quote an example to I have used before. 'The species homo sapiens have 32 teeth, all of which can be removed and replaced by artificial ones, often with better aesthetic appearance and function. The same species is only provided with two eyes, which can never be replaced neither for better aesthetic appearance nor function and every care must be taken to preserve the appearance and functions of the eyes. Yet the resources that many governments provide for the dental care far exceed the resources provided for the care

of the eyes. I am not decrying the need for good dental care which is important, my reason is to purely to illustrate that current medical priorities have gone wrong and surely must be remedied.

Further the ophthalmologists must extend his reach of professional knowledge to the wider community and not just limit it to his clinic, be it hospital or private. He must take the lead in administrative decision making and ensure eye health and curative programmes form an important part of national health programmes whether they are at primary, secondary or tertiary levels. He should ensure an improvement in the resources available for community eye care and that these programmes are simple and cost effective. He must ask for and shoulder greater administrative responsibilities which are equal to those of his other medical colleagues in the health medical and surgical specialities. He must emulate and follow in the footsteps of leaders like Dr Kwa, look for challenges in medical administration, occupy posts as medical superintendents and perhaps even as Director of Medical Services. A greater interest in administration is important if we are to meet our goals.

Manpower Needs

We need to correct the chronic shortage of good ophthalmologists and this should be a priority. The responsibility to improve and increase our numbers rests to a good extent with the teachers of ophthalmology. Those of us responsible for undergraduate training must not only teach medical students to recognise and treat eye disease but also inspire the brighter ones to make ophthalmology their life's vocation. Further, young medical officers doing routine postings in ophthalmology if found to have the aptitude to be encouraged if not persuaded to continue in ophthalmology. Those who are looking for an easy job with no night duties should be quickly transferred to other departments, The number of training posts in ophthalmology must be necessarily be increased and we must be on the lookout for bright, hardworking, young medical officers to fill these posts and motivate them towards a like time in ophthalmology.

Most ophthalmologists unfortunately are likely to remain in the city centres but a high proportion of blindness is in the rural areas because of remoteness of ophthalmic services. In addition to the remoteness of distance there is also the distance of poverty. The rural towns with the surrounding vllages and kampung do not receive any specialist eye service. We are also custodians of their eyes and they too must be brought within the reach of curative eye services and we need to strengthen rural eye health. At present this can only be done through mobile eye clinics staffed by trained ophthalmic assistants who need not be medically qualified. These trained ophthalmic assistants need to be proficient in basic recognition of eye diseases, in preventive care through spreading knowledge of eye health and in treatment including delivery of basic eye surgery. They will then be our extended hands to bring within reach of cure the blind in the rural areas. These rural services, staffed by ophthalmic assistants have proved their worth in many countries and must necessarily be integrated with and form part of the national programme for the Prevention of Blindness. If well trained and given ongoing support from ophthalmologists they can deliver high quality care. The International Council of Ophthalmology and the International Agency for Prevention of Blindness has affirmed the validity and importance of this approach and encourages every country to consider its own needs for training ophthalmic assistants.

Cost-effective

Next we need to reduce costs and ensure community eye-care is cost effective and within the means of the average majority and not just the selected rich. The costs of eye surgery could be reduced by performing most intraocular and extraocular procedures under local anaethesia. It is safe, it is cheap requiring 5 cc of lignocaine or similar preparation. It is fast, reducing threatre time and staff requirement by half. Post-operative recovery is fast, hospital stay is reduced to a day or two, postponement are rare thus reducing waiting lists. In contrast general anaethesia requires an anaethesiologists and his staff (an expensive and rare commodity). It doubles threatre time, increases hospital stay, postponements occur, all leading to longer waiting lists. Sore throats and bronchitis are common even an occasional death which could lead to expensive litigation and damages. All this trebles and quadruples and costs of eye surgery. Instruments should be basic and simple. Individual idiosyncrasys and personal preferences should be left to the individual, to satisfy this whim. A disposable razor blade fragment costing a few cents is as good as a diamond knife costing a few hundred dollars which also requires a technician to keep it sharp. Cost of procedures requiring expensive equipment such as FFA or laser treatment can be reduced through co-operative sharing of facilities. It is expensive business sinking half your capital on one instrument which you would use for only 10 hours a week or less and which would be outdated in a few years. Costs of drugs should be kept low by using simple and locally produced brands which

the patients can afford. May I quote from a paper titled "Priorities in Ophthalmology" by Trevor Ropre, "To give the best treatment to the greatest number of patients in need we must constantly check our priorities. We must combat the whole force of the rich and ruthless Health Care Industry. Do we really believe those sedative statements we find ourselves making about the importance of 'Eye Care', regular checks, etc? Normal eyes should be left in peace; and where the patients, who is conditioned to expect medicines, demands treatment don't give him the latest antibiotics, but the cheapest of the locally produced salves that will keep him happy. And only when major eye diseases need specific remedy, choose that drug which the patient, the hospital and your country can well afford without thereby restricting its services to others. And we must always remember that Small is nearly always Good, and Simple is even better than Small." I mentioned earlier that Malaysian prime minister Dr Mahatier suggested mass surgery to cut costs, a Dr Svyatosiav Fyodorov has introduced Assembly line eye surgery with 20 operations in an hour. He claimed this is very skilled surgery and is a medical revolution, equivalent of the technological and industrial revolutions. He says this assembly line surgery is more precise, less costly and has dramatically reduced complications of refractive visual surgery.

Community Involvement
Next an ophthalmologist must never forget that he is first a member of this community, next a medical practitioner and only then an ophthalmologist. This means that he must not only take a keen interest in eye care but also involve himself in the work of various agencies and programmes concerned with sound health such as good nutrition, control of infections, metabolic and systemic diseases, prevention of injuries and so on. As a human being he must consider it his duty to play a significant and useful role in assisting the blind, particularly the partially blind, to lead fuller and richer lives. He must contribute his share to agencies that look after the welfare of these unfortunate persons and contribute to their training to enable them to make the best use of their other faculties and their limited vision.

As guardians of vision we must be scientific and science is truth. Ophthalmology is a great science and science is truth. Ophthalmologists must be honest with their work, must constantly fight against self-interest, complacency and smugness. His objective is to serve his patients and his community. Selfishness, individuality and self-interest has no place in community care. Short term gains and progress which is not sustained is not progress. Also progress is not just being different, satisfying a personal whim, nor making things difficult. He must constantly re-evaluate the work he is doing, be soul searching for the truth will always surface.

In the UK the blind form 0.2% of the people overall. The WHO figures of overall average is 2.6% most of whom live in the urban slums and the rural areas of developing countries. Technically 80% of this "avoidable blindness" if within reach of preventive and curative services. They are blind and remain blind because they are "outside the system" of eye care. It is our responsibility as professionals, as ophthalmologists as custodians of our community's eyes to bring these unfortunate within the system. May I conclude by again quoting Prof jones "Will we the custodians of eye in health and in disease be found wanting. Will the year 2000 see an ever increasing flow of avoidable blindness from cataract and cornea disease or will these monsters be receding into the history as the new century advances- who will take up the challenge- individually, nationally and internationally?" We all surely will play our part.