1981 – 1982

Brian Leslie **CORNISH** (1924 - 2017)

OAM RFD ED MB BS(Adel) FRCS(Edin) FRCS FRACS FA(Orth)A

Professional Advancement

L O Betts Memorial Award

Military Service RSL

Military Service DVA

Celebrating 125 years: Presidential Article

CV

Obituary

BRIAN L. CORNISH

AM, MB,BS,(Adel), FRCS(Eng), FRCS(Edin), FRACS, RFD, ED, FAMA

CURRICULUM VITAE (March '06)

DATE OF BIRTH: 30 December 1924

EDUCATION:

Hamilton & Western District College, Hamilton, Victoria.
University of Adelaide.

NATIONAL AWARDS:

Member of the Order of Australia	2013
Order of Australia Medal	1993
Reserve Forces Decoration (RFD)	
Efficiency Decoration (ED)	

OTHER AWARDS:

L.O.Betts Memorial Medal	
for 'outstanding contributions to Australian Orthopaedics'	1989
National Tree Farmer of the Year Award	1998

QUALIFICATIONS:

M.B., B.S. (Adelaide)	1947
FRCS (Edin.)	1955
FRCS (Eng.)	1955
FRACS	1957

MEDICAL PRACTICE:

Resident Medical Officer, Royal Adelaide Hospital	1947-8
R.M.O. Adelaide Childrens' Hospital	1950
General Practice, Kiewa Hydro-electric Scheme, Victoria	1950-51
Anaesthetic and Surgical Registrar, Royal Adelaide Hospital	1952-54
Post-graduate Surgical training, Great Britain	1954-56
(Resident Surgical Officer, Connaught Hospital, London)	
Surgeon, Hamilton, Victoria	1956-58
Orthopaedic Surgery: Teaching Hospital and Private Practice Adelaide	1959–2000

HOSPITAL APPOINTMENTS:

Royal Adelaide Hospital:

Honorary Orthopaedic and Spinal Injuries Surgeon	1959–68
Senior Visiting Orthopaedic Surgeon (Unit Chief)	1968–84
Director (founding), Accident and Emergency Service	1975-7
Senior Visiting Surgeon (Unit Chief), S.A. Spinal Injuries Unit	1972–84
(Medical officer to the unit from its inception in 1961)	
Emeritus Surgeon, Department of Orthopaedic Surgery and Trauma, University of Adelaide, Royal Adelaide Hospital	1985–

Repatriation General Hospital:

Visiting Orthopaedic Surgeon.

TEACHING:

Clinical Lecturer in Orthopaedics, University of Adelaide	1960–95
Orthopaedic Registrar Training Program, Adelaide	
Fiji Orthopaedic Training Program.	
Lecturer to Nurses and Allied groups	1960–84.
Visiting Orthopaedic Surgeon, Fiji Orthopaedic Training Program, Lautoka/Suva, for 1 month each	1987, 1991, 1992

MILITARY SERVICE:

Interim Army, RAAMC, B.C.O.F. Japan, (T/Major)	1949-50
C.M.F/Army Reserve)	1958 - 84
Orthopaedic Surgeon, Civilian Surgical Team, Bien Hoa, South Vietnam	1967
Senior Surgeon, First Australian Field Hospital, Vung Tau, South Vietnam	1968,1969
O/C Surgical Service, 1 Aust. Field Hospital, Vung Tau, South Vietnam (promoted Lt Colonel)	1968-69
Consultant Orthopaedic Surgeon, Army Directorate, Canberra	1972–84
(promoted Colonel)	1976

VOLUNTARY ASSOCIATIONS:

The Adelaide Bone and Joint Research Foundation:

Chairman of Board of Governors	1982–01

Australian Orthopaedic Association:

Member	1962-
Vice President	1985
Chairman, SA Branch	1974-5

Paraplegic and Quadriplegic Association of SA

Foundation member	
Vice-President	
Life Member	

Bedford Industries Vocational Rehabilitation Inc.

Director	
Medical Panel Member	
Life Member	1965-85

Medical Defence Association of SA

Chairman	1966-95
Member Board and Cases Committee	1977- 82

Medical Services Review Tribunal

Inaugural Member	1984– 96

ACROD: National Committee on Spinal Injuries

Chairman

Accommodation and Care Subcommittee ACROD (SA)

Chairman

SA Management Committee

Member

Board Member/Director

St. Andrews Private Hospital

Wakefield Memorial Private Hospital

Mutual Community Health Fund

Australian Medical Association (SA Branch)

President	1981 – 82
Life Member	
Fellow of the Australian Medical Association	1986

SA Statutory Boards of Physiotherapy and Medicine

Member

PUBLICATIONS AND PAPERS: (Selected)

1. Traumatic Spondylolisthesis of the Axis: B.L.Cornish, Journal of Bone & Joint Surgery vol.50B, No.1, Feb.1968.
2. Fracture of the Bony Ring of the Axis: Effendi, Cornish, Dussault, Laurin, JBJS pp319-327 No.3 Vol. 63-B 1981.
3. Delayed Primary Closure in Wound Surgery; Paper, RACS meeting, Alice Springs, July 1982
4. Wear of Hip Arthroplasty Acetabular Components: D.W.Howie, Y.Wiadrowski, B.Cornish. Transactions 35th. Ann. Meeting, Orth, Res. Soc. Las Vegas p407, 1989.
5. The Viability of the Femoral Head Following Resurfacing Hip Arthroplasty in Humans: Clin. Orthop. 1993; 291,171-184.

OTHER INTERESTS:

Australian Forest Growers, SA Chapter

Member	1980 -
Chairman	1995-02

Goolwa Regatta Yacht Club

Member	1975-02

Royal Adelaide Golf Club

Member	1992 –

Adelaide Club

Member	1971-
President	2005-06

RECREATIONAL INTERESTS:

Sailing
Farming
Golf.

PRESIDENTIAL ADDRESS — 1982

THE FOLLOWING ADDRESS WAS PRESENTED BY THE RETIRING PRESIDENT (MR. BRIAN CORNISH) AT THE ANNUAL GENERAL MEETING ON 23rd JUNE, 1982

There have been several issues this year which give cause for reflection on the dynamics of health as a social and economic issue, relative to the treatment and prophylaxis of disease. It is therefore proposed to make some observations on ethical matters, the politics of lifestyle (or is it health?), consumerism, and the regulation of the profession.

Professor Ian Kennedy of the Law Faculty, London University, in his Reith Memorial Lectures on the B.B.C. in 1980, opened up the subject widely and stated that "doctors are not necessarily the only or the best people to comment on these matters", because of preconceived attitudes. He exorted the public to "become masters of medicine and not its servant".

This statement has been interpreted as a request for doctors to stop playing God — Kennedy's medicine (with a small 'm') being taken by many, especially our detractors, to mean the medical profession and that the scope of activities by the profession requires constraint. That such a body of opinion exists, either flowing form Kennedy or independently, has shown up in certain projected legislative initiatives in South Australia such as the Natural Death Act and changes to the Medical Practitioners Act.

Public utterances of the S.A. Minister of Health, the Hon. Mrs. Jennifer Adamson, are indicative of the breadth and depth of this interest. In August, 1981, she stated inter alia:

> "....questions of medical ethics affect the whole of society and therefore society had a right to be involved in the determination of such questions."

She went on to say that:-

> "For this reason I have advised the Medical Board of South Australia that I intend to recommend that the Medical Practitioners Act be amended to provide for lay membership."

Fortunately, Branch Council agrees in principle with the action, but for reasons of consumerism rather than bioethical considerations. The profession itself is, of course, part of contemporary society. Doctors are consumers and an increasing proportion of their patients are also professionals who have their own ethos and ethics. Flowing from this, there is a greater community awareness and interest in standards and accountability.

Kennedy, in fact seemed to be saying something quite different from urging doctors to stop playing God. At one point he states:-

> "A respectable argument can be made for the view that the institution of medicine should reflect the views and values of society at large and that from this may then flow in time a different and more equal relationship between doctor and patient."

He then amplified this by recommending the establishment of principles by the community — presumably of a legislative nature — which would serve to guide and define but not destroy the discretion to be exercised by the professional in making clinical decisions. He appeared to be very conscious of the inability of committees to decide particular clinical problems.

THERE CAN REALLY BE NO QUARREL WITH THIS POINT: ADVANCES IN THE SCIENCE AND TECHNOLOGY OF MEDICINE HAVE OUTSTRIPPED THE SOCIAL AND LEGAL GUIDELINES BY WHICH WE LIVE, SO THAT MEDICAL DECISION-MAKING CAN LACK COMMUNITY SUPPORT AND CONSENSUS: THERE IS THUS A DILEMMA AT THE BIO-ETHICAL LEVEL AND NOT SURPRISINGLY, SUCH ISSUES CAN POLARISE TO A POINT WHERE THERE IS RECOURSE TO THE LAW, THE TEMPO OF WHICH IS PECULIARLY UNSUITED TO THESE PROBLEMS.

The medical profession cannot take exception to wide community discussion on issues which have perhaps traditionally been regarded as sacrasanct. Issues such as research and experimentation, aspects of death and dying, transplant surgery, harvesting of tissues — regenerative and non-regenerative, including the maintenance of these so called neomort tissues and bodies in bio-emporia, not to mention such matters as in vitro fertilisation, surrogate motherhood in the human and primate, the rights of the adopted child and those of the child following artificial insemination. It is this community awareness which has already led to legislation such as that against discrimination in regard to sex or disability. You may note that I have not mentioned the rights of the unborn child — as other social pressures develop, these appear to be getting progressively bleak.

There is no doubt whatsoever that informed discussion and greater community awareness concerning these various issues, coupled with sensibly constrained legislation will make for a much better general framework within which doctors can, in an effective and timely manner, discuss such issues with their patients. If this were achieved, I believe we would then in fact be moving TOWARDS the Kennedy model of an equal relationship and away from the land of committees, so dear to the hearts of our politicians.

In considering the function of doctors in the community, it is essential to identify their areas of influence, that is in the prevention and treatment of disease in the individual and not expect that by legislation, even of the most draconian nature (and such measures are in the shadows in this State), that matters relating to health, which in fact arise from social and economic factors, will be influenced by endeavouring to manipulate the medical profession.

To quote Sir Douglas Black, President of the Royal College of Physicians:

> "Most doctors are so busy mitigating the effects of illness that they spend little time conceptualising it. They are trained professionals responding to patient need both in terms of caring and curing — this surely was, is and always will be good medicine."

There is no doubt that the profession in this country has had an enormous influence on Government in educating the public towards a better lifestyle by the promotion of fitness and health. One has only to look at the various programmes which have been initiated from within the A.M.A. itself, and from the Royal Colleges, to find support for this argument. Such matters as preventive measures in heart disease; the dangers of cigarette smoking; the influence of diet and exercise on health; the relationship between alcohol and road safety; water safety and the hazards of drowning; all have been given strong publicity in the last twelve months.

Effective enabling legislation has in certain instances followed these programmes, such as that relating to the wearing of seat belts for motorists, crash helmets for motor cyclists and random breath testing for drivers. This kind of sequence illustrates the point that general health measures in the community are relatively independent of the treatment of disease and that social and economic pressures play a major role — health, in this context, quite clearly not being the summation of the absence of disease in each individual.

Yet, even here, attacks on acute medical care generally ignore the influence it has on life expectation and the prevention of chronic disability, which of itself carries high cost in human and economic terms — a point strongly made by Mr. Paul Gross in the recent Quality Assurance seminar in Adelaide. Similar support comes from Dr. David Roder's figures for South Australia relating to a theoretical reduction of 2,600 deaths this year compared with mortality statistics of just ten years ago.

When one looks at these issues therefore, it is clear that a health care system cannot be changed by endeavouring to force a choice between the broad preventive factors affecting health on the one hand and intervention on the other — the so called medical model in the treatment of disease. Rather it is necessary for society as a whole to determine what it can afford. Resources can be switched or regarded in priority but facilities and skills are commodities which disappear with excessive manipulation and external pressure. The dilemma for the politician is of course, that preventive measures are slow and somewhat evolutionary; some are helped by legislation and others by the educative process and whilst they clearly complement acute care, straight out diversion of resources from acute care cannot be achieved without human, and I feel certain, political cost.

Incidentally if there is a group in medicine which is particularly suited to perceive needs and to respond to these major issues, it is the general practitioner element which is in by far the best position to identify them at a "grass roots" level and to point up social problems, as well as those of particular disease areas. It is hoped that as the channels of communication are established and become more effective through their College, their collective voice will strengthen and offer a greater level of guidance at the interface of prevention versus intervention.

If we continue to reduce resources in acute care facilities, especially in our much maligned hospital system — maligned for its ability to swallow resources — there will be conspicuous delays and deficiencies in treatment of conditions which have unarguable rights for attention as judged by the social standards of our contemporary society and as these financial screws are tightened to a level where it shows in lengthening waiting lists and increasing morbidity, political repercussions must follow.

It is, of course, so convenient for our legislators to attack the profession and to use it as the scapegoat for all the health-related ills in our society. Yet, for all their deafening rhetoric, Governments seem very slow to enact measures directed towards limiting environmental hazards and factors clearly influencing fitness or affecting what is perceived to be an optimum lifestyle. Continuing Government subsidy for tobacco growing and an absence of constraint on tobacco product advertising is a prime example. There is plenty of discussion on these issues but action is apparently too costly at a political level — it is so much easier to adopt diversionary tactics and wail about escalating health care costs.

From speaking generally of decision-making, I turn to the individual level where it is a process of rational consideration by the doctor and his patient of factors leading to an agreed course of action — this, to me, is informed consent. The notion that the signing of a piece of paper is witness to informed consent is, of course, rubbish. The more complicated the written consent the greater the risk of it being construed as a contract and of it becoming an alternative and substitute for effective communication and understanding of a planned course of action. Such a course implies that all matters have been fully covered, no further checks are needed and it presumes that there is no likelihood of changing circumstances either in personnel involved in management or in the clinical condition. Anything beyond a simple authority is surely dangerous and lies in ambush for its signatories.

Complicated written authority goes hand in hand with a proliferation of regulatory agencies, multiple opinions and clinical indecision. It detracts from and does not enhance accountability.

In general the patient wants to know if there is an illness present, whether it can be remedied and by what means; he/she would expect to be informed of the various options and to be a partner in the decision-making. The search for multiple opinions and advice in the name of absolute certainty and safety is often counter-productive in terms of

management, as well as being very expensive; it stultifies initiative and forces the doctor into a defensive position.

Having said that, errors can and do occur in terms of making bad judgements and from inexperience. Larsen, an Oregon orthopaedic surgeon on being asked how one acquired clinical judgement — an attribute he obviously valued — replied by saying it was a matter of experience. Naturally, he was asked how this was acquired; his reply was quite simple — it came from making bad judgements. Hippocrates said it more succinctly: "Experience is fallacious and judgement difficult." Obviously there must be mechanisms for redress of mistakes but, equally, such mechanisms should allow a sensible and balanced appraisal of such situations so that the profession and its individual doctors are not pilloried for circumstances in which something simply went wrong — this being an inevitability, given the known complexity of the human condition and the matching complexity of modern management protocols.

The forces of consumerism bearing on this issue are commonly presented as being opposed to the collective interests of doctors but I contend that this is fallacious. The patient expects and deserves a courteous hearing, not only to discuss in an open and informative way the issues of his health, he also has a right to expect that a doctor will hear perceived criticisms with tolerance and understanding. A lack of effective communication paves the way for confrontation, a situation commented upon by Sir William Osler as follows . . .

> "If we had only to deal with one another the difficulty would be slight, but it must be confessed that the practice of medicine among our fellow creatures is often a testy and choleric business. When one has done his best or when a mistake has arisen through lack of special knowledge, but more particularly when, as so often happens, our hearts best sympathies have been engaged, to be misunderstood by the patient and his friends, to have evil motives imputed and to be maligned, is too much for human endurance and justifies a righteous indignation."

Should there be a breakdown in the patient/doctor relationship, there is and always has been recourse to the law, but the criticism levelled at existing mechanisms is the relative inaccessibility of redress and the difficulty of achieving a balance of evidence in matters involving technical issues.

The present Medical Practitioners Act is certainly deficient in this area and it is hoped that in amendments to it, a more effective preliminary mechanism for the airing of complaints can be developed in regulatory procedures.

I am indebted to Professor Gus Fraenkel, speaking at the recent Quality Assurance Seminar for his observations on the South Australian Act relative to the function of the General Medical Council of Great Britain. In South Australia we have, and I quote from the Act, "an ordinance to define the qualifications of medical practitioners in this Province for certain purposes", passed by the Legislative Council of the Province of South Australia in December, 1844. The "certain purposes" were in relation to inquests, enquiries, trials and post mortems. It gave no lead as to a philosophical basis for the regulation and registration of the profession and, in particular, made no reference to standards and, whilst a concern for the public interest may be inferred, it is not stated. There was not then and there still is not any reference to the quality or standard of educational methods of medical schools presenting graduates for registration, beyond identification of a particular medical registration. In the mechanism for receiving complaints, the procedures for hearing them and in the range of options for dealing with them, the present Medical Practitioners Act falls short — largely, it would seem, because of the narrow concept upon which its origins are based.

As Fraenkel points out, the General Medical Council of the United Kingdom is in a much better position to deal with the broad issues of quality as well as registration and regulation because of its original charter, based on the Medical Act of 1858, which stated in its preamble... "It is expedient that persons requiring medical aid should be enabled to distinguish qualified and unqualified practitioners'. The General Medical Council's own booklet on its functions, having quoted this extract, goes on to say "The whole of the Council's functions flow from that original objective.... It can be said that the general duty of the Council is to protect the public, in particular by keeping and publishing the Register of duly qualified doctors, by ensuring that the educational standard of entry to the Register (and thus to the profession) is maintained and by taking disciplinary action if by reason of misconduct they may be unfit to remain on the Register."

Additionally, the Merrison Report of 1975, arising from the Committee of Enquiry into the Regulation of the Medical Profession in the United Kingdom, says that "The General Medical Council is merely the instrument for the proper supervision of a contract between the public and the profession and that it derives its authority, indeed its being, from legislation." It goes on to say "Parliament acts in this contract for the public, and it is for Parliament to decide the nature of the contract and the way it is to be executed."

Similarly, the Medical Board of South Australia is constrained by the Medical Practitioners Act and clearly, if the Act does not address itself to elements and issues seen to be relevant in society, it is not a matter for the Board to bend the Act, the Board can and I believe does report its limitations; no amount of criticism or condemnation can alter these limitations. For changes in function, Parliament must amend the Act.

The major differences between the G.M.C. and the State Acts in Australia are that the latter do not in general address themselves to the supervision of medical education, whilst the G.M.C. regards this as a major element of its function, as already indicated. Indeed, as Professor Saint pointed out recently at the same Quality Control Seminar, because of this major deficiency in Australian State Acts, we are, by default, still very dependent upon G.M.C. guidelines in this area. For instance each new Medical School as it developed in Australia was obliged to seek recognition by Australian State Medical Boards via the General Medical Council. He considers we are much in need of a National Medical Council in Australia today, modelled on the G.M.C.

Be that as it may, it would seem that some States, e.g. N.S.W. — whilst still lacking a philosophical raison d'etre have already moved to cover some of these areas and the Minister in South Australia has signalled her intention to follow N.S.W. However, one of the important matters which flows from the basic tenet of G.M.C. function, other than the identification of the individual by registration, and by the regulation of his function, is to protect the public from unqualified practitioners. Stre placed on the fact that it is charged with a clear obligation to ensur only registered medical practitioners can, for instance, hold medical appointments in hospitals. Also disciplinary action is taken against doctors who "cover" (this is the expression used officially), and work in conjunction with unqualified practitioners.

There would seem to be an urgent need for similar provisions in our Act having regard to the breadth of services being delivered by other health providers in our community. I am certain that a lack of action here will become increasingly serious as the profession works further on its own internal mechanisms of delineation and quality control — particularly in hospital based practice.

In this context the A.M.A., as the major professional body of doctors, has a vital interest in and has developed attitudes and policies for the regulation of clinical activity of doctors.

One only has to look at the joint venture between the A.M.A., the Health Commission and the Hospitals Association, in the development of guidelines for the delineation of clinical privileges in non-teaching hospitals seeking to influence the quality of delivery of medical care, to see evidence of this leadership. It is quite apparent that with sensible and balanced approaches, effective attitudes can be developed and can be expressed in legislative action which then confers benefit on the community as a whole and at the same time avoids detraction from the professionalism of medicine.

I believe it is reasonable and very much in the public interest that amendments to the Act, not only address themselves to matters of competence by doctors, but apply the same standards to providers of health care in overlapping disciplines. Both sides of the House in our State Legislature have indicated their intention to act in these r indeed the Malvoleos within the profession have also had their say — or without declaring ambitions of achieving greatness or having it thrust upon them.

Whilst acknowledging that contemporary pressures of consumerism demand lay representation in regulatory procedures so that justice can be seen to be done, this can only go so far in terms of determining clinical competence. Adjudication upon this aspect cannot be determined outside the profession; it can only be a peer group which sets the benchmark and then upon its advice, the statutory body with its lay representatives would be able to act. Any deviation from this approach would open the way for manipulation and interference in legitimate medical practice.

It is therefore appropriate that the warning is sounded and the point made that maturity and wisdom cannot be imported from outside our profession for its own effective regulation.

In this regard I would like to approach the end of my address with a further quote from the Merrison Report of 1975.

> "We take the view that the medical profession should be largely self-regulated. The principle reason for our view is that we have no doubt that the most effective safeguard of the public is the self-respect of the profession itself and that we should do everything to foster that self-respect. The evidence put to us by the profession through various professional bodies was devoted almost entirely to the question of how the profession might best serve the public interest, how it might be ensured that doctors of only the highest competence

were put on the Register, and how the professionally incompetent might most effectively and justly be removed from the Register."

Ladies and Gentlemen, there seems little doubt that the bioethical problems, the social and economic issues versus curative medicine, and the Medical Practitioners Act — will continue to be debated. It is earnestly hoped that any legislation arising from these issues, which finds its way onto the Statute Books of South Australia, is genuinely aimed at improving health.

Initiatives which are good for health are good for medicine and good for the A.M.A.