BREAKING THROUGH THE PAIN BARRIER

The Extraordinary Life of Dr Michael J. Cousins

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Declaration of Authorship

Statement of originality

This is to certify that, to the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes. I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.

Gabriella Kelly-Davies

Authorship Attribution Statement

This thesis contains material published in the biography I wrote: *Breaking Through The Pain Barrier. The Extraordinary Life of Dr Michael J. Cousins* (Brisbane: Hawkeye Publishing, 2021).

It also includes material from six of my publications:

- Gabriella Kelly-Davies, Rollin M Gallagher, Daniel Carr, 'In Memoriam: Professor Michael J. Cousins', *Pain Medicine*, 28 August 2024, pnae086, https://doi.org/10.1093/pm/pnae086.
- 'Cousins, Michael John (1939–2024)', Obituaries Australia, National Centre of Biography, Australian National University, accessed 7 September 2024, https://oa.anu.edu.au/obituary/cousins-michael-john-34409/text43192.
- 'How *Does* One Choose Narrative Strategy? One Biographer's Experience', *Australian Journal of Biography and History*, no. 8 (February 2024): 173–87.
- 'How *Do* You Write the Biography of a Living Scientist?' *Women's Ink,* The Society of Women Writers NSW Inc. (Winter 2022): 14–17.

- ‘The Changing World of the Biography’, *Women’s Ink*, The Society of Women Writers NSW Inc. (Winter 2021): 6–9.
- ‘Discovering Narrative Voice’, *Faber Writing Academy News*, November 2020.

It also includes material from three of my presentations:

- Mary Chitty, ‘Panel Recap: Melding Science and Biography’, *Biographers’ Craft*, Biographers International Organization, 1 June 2024.
- ‘Narrative Choices in Biography’, State Library of New South Wales, 21 October 2022, bit.ly/3XCN3O6.
- ‘How *Does* One Write the Biography of a Living Scientist?’ National Science Week, Mosman Library, Sydney, 19 August 2022, bit.ly/3j5ulQc.

I also host a podcast ‘Biographers in Conversation’ (www.biographersinconversation.com) and publish a blog (https://www.shareyourlifestory.com.au/blog/) that contain several of the ideas presented in this exegesis.

Copyeditor

Dr Rani Kerin copyedited this thesis. Her doctoral thesis ‘Doctor Do-Good: Charles Duguid and Aboriginal Politics, 1930s–1970s’ was later published as a monograph. She worked as a research fellow in the National Centre of Biography (ANU) from 2010 to 2013 and since then has worked part-time as a research editor with the *Australian Dictionary of Biography*. Dr Kerin is an accredited editor and a full member of the Institute for Professional Editors. Her contribution was limited to copyediting the text and she did not offer advice other than spelling, grammar and punctuation.

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Abstract

This is a creative, practice-led thesis comprising a biography as the creative component and an exegesis as the theoretical element. The biography, 'Breaking through the Pain Barrier: The Extraordinary Life of Dr Michael J. Cousins', shares the life story of Dr Michael Cousins, Australia's pre-eminent pain medicine pioneer. During the second half of the twentieth century, when pain was still viewed as a 'dead-end' area of medicine, Cousins inspired and led teams of equally dedicated colleagues to build the field of pain medicine in Australia.

An earlier iteration of the biography was published as a book in 2021; however, the biography presented for examination is a completely rewritten version based on new evidence from archives that were closed during the height of the COVID-19 pandemic.

The exegesis, 'Choices, Choices, Choices: One Biographer's Experience', explores the multiplicity of choices I made while researching, drafting, publishing and rewriting the biography. The first chapter considers how my choices were influenced by the complexity of scientific and medical research and the imperative to translate it into a captivating narrative for the general reader. Chapter Two examines the decisions I made while striving to balance Cousins's human story with his scientific and public lives, and Chapter Three considers how I navigated the perils of writing about a living subject, including privacy, moral and ethical concerns. Chapter Four analyses my choices about authorial voice, plot, structure, the use of novelistic devices, interpretation and other aspects of narrative strategy. And Chapter Five reflects on my experiences and learnings as I rewrote the published manuscript based on new evidence.

In this thesis, 'Choices, Choices, Choices' is presented first to provide theoretical, background and contextual information. The biography 'Breaking through the Pain Barrier' is presented after the exegesis (Part II).

Acknowledgements

My heartfelt thanks to Michele and the late Michael Cousins. I realise it was confronting to have someone probing into your private life; however, you were unendingly open and gracious, and I deeply appreciate it. I owe a great debt of gratitude to the dozens of family members, colleagues, associates, friends and acquaintances I interviewed, often multiple times. Laurie Mather, in particular, tirelessly responded to my endless questions. And thanks too to Michael Cousins's patients who trusted me with their intensely personal stories.

My sincerest thanks to my supervisors, Associate Professor Susan Thomas, Dr Malcolm Allbrook and Professor Paul Glare, whose advice, support and encouragement I value immensely. Also, special thanks to Professor Erica Charters, my supervisor while a visiting doctoral student at the Centre for Life Writing at Oxford University, and Dr Alice Little, who arranged my visit and ongoing relationship with the centre.

I am deeply grateful to the dedicated archivists and librarians who so generously supported my research: Laura Foley, Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine; Veronica Dominiak, Geoffrey Kaye Museum of Anaesthetic History; Associate Professor Catherine Storey, Royal North Shore Hospital and Sydney University's Medical School; Mary Clare O'Brien, Gus Fraenkel Collection at Flinders University; Dr Alison Peck, Flinders University; Dr Elizabeth Daniels and Helen Fuller, La Trobe University; Dr Marcia Meldrum, John C. Liebeskind History of Pain Collection at the University of California, Los Angeles; Joan O'Malley, Maude Abbott Medical Museum at McGill University; and Katie Lai, Osler Library of the History of Medicine at McGill University.

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I am eternally grateful to my ever-supportive and loving husband Ian Davies, my fellow detective, sounding board and anchor.

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Abbreviations

AAP	Australian Associated Press
AIHW	Australian Institute of Health and Welfare
AMC	Australian Medical Council
ANU	Australian National University, Canberra
ANZCA	Australian and New Zealand College of Anaesthetists, Melbourne
APS	Australian Pain Society, Sydney
BIO	Biographers International Organization, New York
CAPMR	Centre for Anaesthesia and Pain Management Research
FMC	Flinders Medical Centre, Adelaide
FPM	Faculty of Pain Medicine
FU	Flinders University
GF	Gus Fraenkel
GKD	Gabriella Kelly-Davies
GPS	Great Public Schools
IASP	International Association for the Study of Pain
JJB	John J. Bonica
MJC	Michael John Cousins
NHMRC	National Health and Medical Research Council
NSW	New South Wales
PMRC	Pain Management Research Centre
PMRI	Pain Management Research Institute
RNSH	Royal North Shore Hospital, Sydney
RV	Roger Vanderfield
UW	University of Washington
WHO	World Health Organization

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PART I Exegesis

Choices, Choices, Choices:

One Biographer's Experience

Introduction

At the 2021 Sydney Writers' Festival, the journalist and writer Osman Faruqi explored the choices confronting every non-fiction writer. Faruqi's presentation resonated with me because of the myriad choices I faced while writing 'Breaking through the Pain Barrier. The Extraordinary Life of Dr Michael J. Cousins,' my biography of Australia's foremost pain medicine pioneer. That afternoon, I decided my exegesis, 'Choices, Choices, Choices: One Biographer's Experience', would explore the choices I made while researching, drafting and publishing the biography.

Each choice involved one or more questions, and, by viewing them as an entity, I formed my research question: How *does* one write the biography of a living scientist? This question was inspired by one Virginia Woolf voiced in a letter to Vita Sackville-West while writing the biography of the artist Roger Fry: 'My God, how *does* one write a biography?'[1]

Eugen Bacon likens a scholarly exegesis to a memoir of the creative process. She believes an exegesis demonstrates the production of knowledge:

> In it, the researcher describes the process of creating, articulates and searches for answers to a research question refined across stages of the study. The exegesis is both a product and a process that involves inward reflection and discernment. As the researcher shapes, substantiates, makes connections between creating art and showing research gains, the emergent exegesis is also a decisive memoir that an examiner must use to determine the logic or illogic of new knowledge through creative art.[2]

Inspired by Bacon, in 'Choices, Choices, Choices' I examine my decisions and the views of biographers and scholars about similar choices. My goal is to contribute to the body of knowledge about the theory, art and craft of biography, with a particular focus on science and medical biography.

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[1] Nigel Nicholson and Joanne Trautmann, eds, *The Letters of Virginia Woolf* (New York: Harcourt, Brace, Jovanovich, 1980), 226, letter dated 3 May 1938.

[2] Eugen Bacon, 'The Scholarly Exegesis as a Memoir', *New Writing* 14, no. 3 (2017): 386.

My Writing Journey

From a young age, I was enthralled by biographies of authors, musicians and artists. It excited me to hear their ideas and opinions and to learn about their relationships and passions. An aspect of their lives I found fascinating was learning how they navigated life's challenges and the lessons they learned.

In my quest to learn about biography, I searched for postgraduate degrees, but the few available were offered at overseas university campuses. Instead, I enrolled in several courses, including Biography and History at the Australian National University (ANU). ANU's course immersed me in the world of biography theory and analysis, and, importantly, the debates. To learn how to write creatively, I studied narrative non-fiction at the University of Sydney and creative writing at the University of Technology, Sydney. I also completed a twelve-month life writing course through Oxford University's Centre for Continuing Education.

In 2020, I joined Biographers International Organization (BIO), which promotes the art and craft of biography through conferences, roundtables and seminars. Becoming a BIO member was a significant turning point and, in 2021, I accepted an invitation by BIO's president to launch a roundtable for science and medical biographers. Our Zoom conversations every month continue to improve my understanding of biography, as does participating in monthly Zoom meetings of a group of biographers who live in Boston. In May 2024, I chaired a panel discussion 'Melding Science and Biography' at BIO's annual conference in New York.

During 2023, I spent the Trinity term at Oxford University's Centre for Life Writing as a visiting doctoral student. Every conversation, tutorial and writing workshop with scholars across biography, life writing, English literature, medical humanities and the history of medicine was a tremendous learning experience. I maintain a strong connection with the Centre for Life Writing by participating in writing workshops, seminars, its research network and a weekly life writing tutorial via Zoom.

After returning to Sydney from Oxford, I launched *Biographers in Conversation*, a weekly podcast of interviews with biographers across the world about the multiplicity of choices they make while researching, drafting and publishing their books.[3]

[3] *Biographers in Conversation* (podcast), https://www.biographersinconversation.com/.

Why Michael Cousins?

On 31 October 1982, as I cycled along a gravel road overlooking Magnetic Island in north Queensland, I revelled in the salty fragrance of the sea air and the fiery touch of the tropical breeze on my face. Suddenly, from the corner of my right eye, I glimpsed an arm thrusting towards me. My next memory was a bright light. It was a doctor at Townsville General Hospital peering into my eyes with a torch. He told me that some young men in a speeding car had pushed me from my bicycle. That day, my twenty-fourth birthday, heralded the onset of daily migraine attacks. It was also my entrée to the medical merry-go-round. After two decades of ricocheting from neurologist to neurologist, and with escalating migraine attacks, my general practitioner referred me to the pain specialist, Dr Michael J. Cousins, who died on 27 April 2024.

Cousins suggested one option was to implant a neurostimulator at the base of my skull. 'It'll block the pain signals', he said. He also recommended I join a multidisciplinary pain management program involving stretching and carefully paced exercise, meditation and psychological techniques. 'It'll teach you how to turn down the volume of pain signals racing through your nervous system', he explained.

During my visits to the pain clinic, Cousins's colleagues told me he had led the pain world in the late 1980s as president of the International Association for the Study of Pain (IASP). In 1976, he founded Australia's first multidisciplinary pain centre at Flinders Medical Centre (FMC) in Adelaide and another at Sydney's Royal North Shore Hospital (RNSH) in 1990, the one I attended. Both were considered centres of excellence in pain research and treatment internationally. In 2010, Cousins led the effort to create Australia's National Pain Strategy, which America, England and several European nations replicated. Further, in 2011, he gained the agreement of representatives from sixty-four nations for the Declaration of Montreal, which states that access to pain management is a universal human right.

I had heard Cousins was a savvy political operator, formidable negotiator and relentless campaigner for the rights of people living with chronic pain. This intrigued me because it contradicted my experience of him as a kind, gentle doctor who was deeply empathetic. It sparked my curiosity about who he was as a person, how he reconciled the conflicting aspects of his character and personality, and what drove him to sacrifice so much to reduce suffering by improving the treatment of pain.

Outside of pain medicine circles, Cousins was relatively unknown. Nonetheless, his story is valuable to share because it holds lessons about tenacity, resilience and courage for aspiring leaders and reformers, irrespective of their field of endeavour. The emergence of pain as a field of medicine from the mid-1970s is an important aspect of Australia's medical history, particularly because 3.4 million Australians—one in five people—live with chronic pain. Moreover, biographies of scientists and doctors provide a lens through which to grasp the role of science in society and the interplay between character, society and scientific progress. This was my inspiration for writing Cousins's life story, though I knew some critics might dismiss it as just another archetypal 'Great Man' biography that glorifies a white, middle-class male. My goal was to craft a deeply nuanced, kaleidoscopic portrait that transcended the legend by examining the complex human being at its core.

In 2018, during a fundraising dinner for pain research, I asked Cousins whether I could write his biography. After several weeks of hesitation, he agreed to cooperate with me. His only caveat was that I allowed him to review medical and scientific information for accuracy and correct any errors; he said the book was mine to write and he would not interfere.

The biography is the creative component of my PhD, so Cousins and the interviewees received a participant information form describing the research project as part of Sydney University's human research ethics approval process. They signed a consent form acknowledging their agreement to take part voluntarily.

The Choices

My first choice was selecting the general reader as my audience, a decision that profoundly influenced the narrative strategy. To learn about pain medicine and prepare for interviews, I studied articles from prominent journals such as *Pain,* the *Journal of Pain* and *Pain Medicine.* Reading the pain medicine literature enabled me to identify potential interviewees and frame interview questions. I also studied *Mosby's Dictionary of Medicine*, *Nursing and Health Professions* to help me grasp complex medical concepts in sufficient depth to translate them into an engaging, accessible narrative.

In January 2019, I conducted the first of eighteen months of weekly conversations with Cousins in his home on Sydney's upper North Shore. He introduced me to twenty-two pain medicine researchers in Australia and around the world, eight of whom had collaborated with him on

projects since 1969 when he embarked on his pain medicine career at McGill University in Montreal and, later, at Stanford University. I knew, however, that if I just relied on interviews with his friends and supporters, I risked idealising him, so I identified another twenty-eight colleagues independently and interviewed them.

Today's readers are more interested in how prominent individuals behave towards and affect ordinary people rather than how a subject rose to an eminent position,[4] so I interviewed ten of Cousins's patients to learn how they perceived him; their remarks corroborated my own experience of his commitment and compassion.

The historian Barbara Caine suggests that, since the rise of feminism in the 1970s, the mothers, wives and daughters of male subjects are now given more prominence in the biographies of eminent men. Today, family relationships are explored and so is the role of the subject's wife or partner in supporting the subject's career and raising their children, often on their own.[5] It was crucial to understand Michele Cousins's point of view because she devoted herself to supporting her husband and his career, so I interviewed her on her own several times. To canvass a broad range of views, I also interviewed family members, friends, politicians, bureaucrats, professional associates and acquaintances.

During 2019 and early 2020, I visited all the places in Sydney that shaped Cousins to sense how they might have influenced him. He accompanied me on visits to RNSH's pain centre, Sydney University's Medical School, Palm Beach, his childhood home in Killara and schools, enabling him to relive his experiences and share them with me. The insights I gained by retracing his footsteps enabled me to reconstruct scenes filled with the sights, sounds and smells he recalled in each setting, and, at critical moments, his thoughts and emotional responses. Before visiting places of significance to him on my own, I listened to his descriptions in recordings, especially his vocabulary and the emotion in his voice, to help me imagine his experiences.

Most buildings and their surrounds had changed significantly during the intervening years, so I searched for photographs and descriptions of each place as they would have appeared during the mid-twentieth century. I also studied *The Centenary Book of the Sydney University Medical*

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[4] Andrew Lownie, in *Life Writing: A Writers' and Artists' Companion*, ed. Sally Cline and Carole Angier (London: Bloomsbury Academic, 2013), 126.

[5] Barbara Caine, *Biography and History,* 2nd ed. (London: Red Globe Press, 2019), 102–3.

Society and *150 Years of the Faculty of Medicine,*[6] which contained photographs and detailed descriptions of the buildings. The online museum of the University of Sydney's School of Medicine[7] was also invaluable as a source of historical information.

Throughout 2019, I studied archives at the Australian and New Zealand College of Anaesthetists (ANZCA) and the Faculty of Pain Medicine (FPM) in Melbourne. In May 2020, I had arranged to study archives at Flinders University and RNSH, however, COVID-19 lockdowns delayed this research. Five months later, I was due to spend two weeks retracing Cousins's footsteps in North America to sense how significant places such as McGill and Stanford had influenced him.

In North America, my other planned destination was the John C. Liebeskind History of Pain Collection at the University of California, Los Angeles, because it contains IASP's extensive archive and the personal and professional papers of three early pain medicine pioneers who inspired and mentored Cousins: John J. Bonica, Ronald Melzack and Patrick Wall. The online catalogue of the John J. Bonica papers lists Box 2, Folder 29 as 'Cousins, Michael J., 1971–1990',[8] a trove of letters, minutes of meetings, memoranda and other evidence about my subject during his ascendancy.

I had also arranged to study a collection of Patrick Wall and Ronald Melzack's papers at the Osler Library of the History of Medicine at McGill University. My plan was to study the archives to relive the experiences of a young Cousins and his interactions with pain medicine's leaders. I was also eager to understand how his mentors and colleagues perceived him. Once again, this research was delayed by COVID. Fortunately, Marcia Meldrum, co-director of the John C. Liebeskind History of Pain Collection, sent me the transcript of an oral history

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[6] Ann Jervie Sefton, Nicholas Cheng and Ian G. Thong, *The Centenary Book of the Sydney University Medical Society* (Sydney: Hale & Iremonger, 1992); Ann Jervie Sefton, Yvonne Cossart and Louise Freckelton, *150 Years of the Faculty of Medicine* (Sydney: Sydney University Press, 2006); James Semple Kerr, 'The Anderson Stuart Building', in *The Centenary Book of the University of Sydney Faculty of Medicine* (Sydney: Hale & Iremonger, 1992).

[7] Sydney Medical School Online Museum and Archive, accessed 8 June 2023, https://www.sydney.edu.au/medicine/museum/mwmuseum/index.php/Sydney_Medical_School_Online_Museum_and_Archive.

[8] Bonica (John J.) Papers, Online Archive of California, https://oac.cdlib.org/findaid/ark:/13030/tf4t1nb37b/dsc/#aspace_ref14_w8t (hereafter Bonica Papers).

interview she conducted with Cousins in 1997, which provided deep insights into Cousins, his colleagues and the historical context in which he worked.[9]

During 2019, I thought deeply about the style of book I intended to write. To help crystallise my thinking, I studied dozens of biographies of doctors and scientists including *American Prometheus: The Triumph and Tragedy of J. Robert Oppenheimer*,[10] *Jonas Salk: A Life*[11] and *Ian Frazer: The Man Who Saved a Million Lives.*[12] I also started studying scholarly biography literature, including *Writing Lives: Principia Biographica*,[13] *Theoretical Discussions of Biography: Approaches from History, Microhistory and Life Writing*,[14] and *The Oxford History of Life Writing*,[15] a series of seven books. *The Oxford History of Life Writing,* which defines life writing in the broadest sense, starts with an analysis of life writing during Medieval times then proceeds through different eras to the late twentieth century and contemporary biography.

To write a captivating life story, I learned it was vital to employ novelistic devices based on corroborated facts, such as reconstructing scenes from a subject's life, enabling readers to feel as if they were present in the action. Other learnings included authorial voice, interpretation, the choice of language, how to construct the plot and avoiding hagiography.

Midway through this project, Cousins was diagnosed with Parkinson's disease. As his health declined, I felt a sense of urgency about finishing the manuscript so he could read it before he became too incapacitated. This situation presented me with a critical decision: should I wait for the pandemic to end before completing the biography so I could include insights from additional archival research, or I should complete the manuscript based on the wealth of

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[9] Michael Cousins, Interview by Marcia Meldrum. 19 October 1997. Ms. Coll. no. 127.10.
John C. Liebeskind History of Pain Collection, History & Special Collections Division, Louise M. Darling Biomedical Library, University of California, Los Angeles.

[10] Kai Bird and Martin J. Sherwin, *American Prometheus: The Triumph and Tragedy of J. Robert Oppenheimer. Biography* (London: Atlantic Books, 2009).

[11] Charlotte DeCroes Jacobs, *Jonas Salk: A Life* (New York: Oxford University Press, 2015).

[12] Madonna King, *Ian Frazer: The Man Who Saved a Million Lives* (Brisbane: University of Queensland Press, 2013).

[13] Leon Edel, *Writing Lives. Principia Biographica* (London: W.W Norton & Company, 1984).

[14] Hans Renders and Binne De Haan, eds, *Theoretical Discussions of Biography: Approaches from History, Microhistory, and Life Writing* (The Netherlands: Brill, 2014).

[15] Patrick Hayes, *The Oxford History of Life-Writing: Volume 7: Postwar to Contemporary, 1945–2020* (Oxford: Oxford University Press, 2022); Karen A. Winstead, *The Oxford History of Life-Writing: Volume 1. The Middle Ages* (Oxford: Oxford University Press, 2018); Alan Stewart, *The Oxford History of Life Writing: Volume 2. Early Modern* (Oxford: Oxford University Press, 2018).

evidence I had already accumulated? While wrestling with this decision, I placed third in the Hawkeye Manuscript Development Prize and Hawkeye offered me a contract to publish the book.

My original plan was to submit the biography to the PhD examiners then seek trade publication. However, by the time Hawkeye offered me a contract, I had conducted over 100 interviews, completed extensive research in Australia's pain medicine archives, and studied the pain medicine literature. Three pain medicine scholars and Cousins had also fact-checked the manuscript.

In 2021, Cousins's rapidly declining health and uncertainty about when archives and Australia's borders would reopen prompted me to accept Hawkeye's offer. However, my inability to access additional archives concerned me deeply: I feared I risked missing vital clues that would enable me to better understand and portray my subject.

The following chapters examine many of the decisions I made while crafting the published and rewritten version of 'Breaking through the Pain Barrier'. For each major decision, I explore the views of scholars and the experiences of other biographers about similar choices, then illustrate my choices through excerpts from the biography. Chapter One explores how my choices were influenced by the complexity of scientific and medical research and the imperative to translate it into an enthralling narrative. Chapter Two examines the decisions I made while striving to balance Cousins's human story with his scientific and public lives, and Chapter Three considers how I navigated the perils of writing about a living subject. Chapter Four analyses my choices about authorial voice, structure, use of fiction techniques, interpretation and other aspects of narrative strategy. And Chapter Five reflects on my learnings from publishing *Breaking Through The Pain Barrier* in 2021 rather than waiting for archives and Australia's international borders to reopen. It also examines my experiences and learnings as I rewrote the published manuscript based on new evidence.

Chapter One: The Alchemy of Science Biography

During the late 1970s, a ferment swept through pain medicine circles because researchers believed they were on the cusp of a new era of eradicating pain. At a conference in 1979 for anaesthetists, pain medicine professionals and surgeons, a prominent American researcher said everyone in the pain world thought the ability to manage pain was close at hand. 'It was a bit of a worldwide mini-explosion of sudden interest in pain', remarked an Australian pain specialist who attended the conference. 'The mood in the room was electric, and everyone felt euphoric.'[1] Unfortunately, later studies revealed that pain is far more complicated than anyone had imagined in those heady days and researchers are still searching for clues on how to manage chronic pain.

Forty-year-old Michael Cousins was engulfed in this wave of exhilaration and optimism gripping pain researchers, giving him the stamina to work eighteen hours every day. The research team he led at Flinders Medical Centre (FMC) was the first to create a new form of epidural analgesia,[2] catapulting him and his colleagues onto the world stage. It triggered an avalanche of invitations for them to speak at prestigious conferences internationally and publish journal articles that are still viewed as seminal within anaesthesia and pain medicine circles.

This chapter explores the choices I made from the perspective of a biographer writing about a doctor engaged in research, clinical practice and leadership roles. It considers how I translated complex technical information into an accessible narrative and selected a structure that would portray Cousins's quest. The chapter also examines how I represented the historical, political and social context in which he operated and how it impacted the achievement of his vision to reduce suffering by improving the treatment of pain.

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[1] Bruce Rounsefell, interview by Gabriella Kelly-Davies (hereafter GKD), 11 November 2019.

[2] Epidural analgesia involves injecting local anaesthetic into the epidural space, which surrounds the dura—the outermost and fibrous of the three membranes surrounding the brain and spinal cord. Peter Harris, Sue Nagy and Nicholas Vardaxis, eds, *Mosby's Dictionary of Medicine, Nursing and Health Professions* (Sydney: Elsevier Health Sciences, 2019), 616.

What to Do with the Science?

An early challenge was deciding how much of the science of pain medicine to include in the narrative. Some authors concentrate on the science, especially if the biography is intended for an academic audience.[3] However, others focus solely on the human story and pay little attention to technical details.[4] Life is a tapestry, suggests the writer Rayvon Fouché, and a biographer's role is to balance the technical, scientific or medical life with a scientist's private and interior lives. Fouché said the three African American inventors he portrayed in *Black Inventors in the Age of Segregation*[5] were 'messy, interesting individuals', and their creativity was not necessarily central to who they were as people. His task, he believed, was to understand them as human beings then grasp what motivated them to do innovative work.[6] This is the approach I employed, integrating the science of pain medicine with Cousins's human story.

Studying the passions behind medical research is vital, suggests the philosophy scholar Michael Polanyi, because it is what drives so much scientific endeavour.[7] So is capturing this scientific passion and the essence of *wonder* in the narrative to satisfy readers' longing to understand what drives scientists to make discoveries.[8]

Cousins possessed an intense passion for pain research and his patients. The following scene from 'Breaking through the Pain Barrier' illustrates his zeal for understanding the science of pain and interacting with kindred spirits. Seated in an overcrowded 250-seat auditorium at the Royal Victoria Hospital in Montreal in 1969, he is listening to a lecture by the neuroscientist Patrick Wall on the revolutionary Gate Control Theory of Pain, which Wall and the McGill psychologist Ronald Melzack proposed in 1965.

> Cousins sat spellbound as Wall, who was tall and skinny, bald on top of his head, and wore a beard and largish square glasses, meticulously described existing concepts of

[3] Mary Jo Nye, 'Scientific Biography: History of Science by Another Means?' *Isis* 97, no. 2 (2006): 324.

[4] Robert Paradowski, 'The Biographical Quest: Some Personal Reflections of a Pauling Biographer on the Art and Science of Scientific Biography', 28 February 1995, https://scarc.library.oregonstate.edu/events/1995paulingconference/video-s2-4-paradowski.html.

[5] Rayvon Fouché, *Black Inventors in the Age of Segregation: Granville T. Woods, Lewis H. Latimer, and Shelby J. Davidson* (Baltimore: John Hopkins University Press, 2003).

[6] Rayvon Fouché, *Biography of Science, Medicine and Innovation*, BIO Virtual Workshop, 6 March 2021, https://www.youtube.com/watch?v=OWO_tBWcnpg.

[7] Michael Polanyi, *Personal Knowledge* (England: Routledge, 2012), 96.

[8] Richard Holmes, *The Age of Wonder: How the Romantic Generation Discovered the Beauty and Terror of Science* (New York: Vintage, 2009), xvi; Richard Holmes, 'The Scientist Within', *Nature* 489 (2012): 498.

> pain, then ‘tore them apart’. The room erupted as Wall’s colleagues reacted to his provocative claims that pain signals flowed in two directions and could be altered in the spinal cord and brain.
>
> As a profession, pain medicine was in its infancy, lacking the resources needed to make breakthrough discoveries about new treatments. After listening to Wall’s lecture, however, Cousins sensed pain would one day be a mainstream field of medicine. Acknowledging that it was not a ‘sexy’ area of medicine—indeed, a few decades earlier it had been considered a ‘taboo subject’ in surgical texts[9]—Wall nevertheless opened Cousins’s eyes to the fast-approaching explosion in knowledge about pain and its treatment. His mind racing with possibilities, Cousins started thinking about research questions he had not thought of before.[10]
>
> …
>
> Melzack and Wall’s original ideas inspired Cousins. The pair described themselves as iconoclasts. Intensely excited by research, they ‘lived and breathed it’. ‘Research is exciting’, Melzack often said. ‘Enthusiasm energises research. Be enthusiastic about your own and others’ research, particularly that of younger people.’[11] These remarks resonated with Cousins, who shared a similar view. He enjoyed meeting people with a similar passion for medical science and he found it electrifying to spend time with his two colleagues.[12]

Translating Complex Medical Concepts

One of the dilemmas of writing about doctors and researchers is converting dense academic content into an enthralling story. My background was in physiotherapy, so I had a basic understanding of medical terminology. However, I struggled to grasp complex aspects of the science of pain medicine. Although Cousins was a natural teacher and he explained theoretical concepts to me in simple terms, I found it challenging to translate them into a captivating narrative that retained scientific integrity. My solution was to describe each term within the narrative then include a technical definition in the footnotes.

The following example shows how I explained the epidural space and epidural analgesia:

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[9] René Kieny, ‘René Leriche and His Work as Time Goes By’, *Annals of Vascular Surgery* 4, no. 2 (1990): 167.

[10] Gabriella Kelly-Davies, ‘Breaking through the Pain Barrier: The Extraordinary Life of Dr Michael J. Cousins’ (PhD thesis, University of Sydney, 2024), 118.

[11] Michael J. Cousins (hereafter MJC), ‘History of Pain Management: Developments in Australia and Beyond’, April 2009, MJC Private Collection.

[12] Gabriella Kelly-Davies, ‘Breaking through the Pain Barrier: The Extraordinary Life of Dr Michael J. Cousins’ (PhD thesis, University of Sydney, 2024), 119.

Story

> Philip Bromage described how he had injected local anaesthetic into the epidural space—the space surrounding the outer membrane of the spinal cord—to relieve pain after patients had crushed their chests in an accident.[13]

Footnotes

> Epidural anaesthesia/analgesia involves injecting local anaesthetic into the epidural space, which surrounds the dura—the outermost and fibrous of the three membranes surrounding the brain and spinal cord.[14]

Explaining complicated pain medicine theories in simple yet precise terms was particularly problematic because they were so discombobulating for a non-scientist. Frustratingly, it took me several months of revising to settle on the following description of the Gate Control Theory of Pain after members of my writing group said early drafts were encyclopaedic and impenetrable:

> Melzack and Wall proposed that something occurred in the spinal cord and at other levels of the nervous system to alter the processing of pain signals. Contrary to other pain researchers, they thought pain signals flowed in two directions through the nervous system—from the injured area of the body up the spinal cord to the brain, then back down the spinal cord to the damaged tissues. This idea contradicted the widely accepted theory of pain proposed by the seventeenth-century philosopher René Descartes. Melzack and Wall believed that one of the weaknesses of Descartes's theory was that it did not explain the cause of phantom limb pain or chronic pain.
>
> The two researchers suggested that 'nerve gates' in the spinal cord controlled the flow of pain signals to the brain. Excitatory chemicals in the nervous system opened the gates, increasing the intensity of the pain, and inhibitory chemicals closed the gates, turning down the volume of pain. If a person felt stressed or anxious, the two researchers thought, the nervous system released excitatory chemicals, opening the gates and intensifying the pain. However, if a person was calm and relaxed, the nervous system released inhibitory chemicals, closing the gates and reducing the pain.[15]

Focusing the story and narrowing the biographical scope were difficult because Cousins, a prolific writer, juggled several academic, clinical and professional roles. As well as writing

[13] Kelly-Davies, 'Breaking through the Pain Barrier', 104.

[14] Harris, Nagy and Vardaxis, *Mosby's Dictionary of Medicine*, 560.; Kelly-Davies, 'Breaking through the Pain Barrier', 104
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[15] Kelly-Davies, 'Breaking through the Pain Barrier', 117.

hundreds of letters, he published 180 journal articles, seventeen letters to editors and fifteen editorials. He also produced six textbooks, 114 reviews and chapters in textbooks, a doctor of medicine thesis and a doctor of science thesis.[16]

Like the historian Thomas Hager, who wrote *Linus Pauling and the Chemistry of Life*,[17] I felt buried under an avalanche of information. Pauling won a Nobel prize for chemistry and the Nobel Peace Prize, published over 500 scientific papers and eleven books, and his endeavours ranged across chemistry, molecular biography, peace activism, government consulting and medicine. After collecting tens of thousands of documents, Hager realised he needed a system for prioritising them. Eventually, he realised the actions of scientists are motivated by the same things most people long for—a need for physical comfort, love, praise and professional satisfaction—so he used these principles to prioritise evidence and frame the biography.[18]

For three months, I experimented with ideas for narrowing the biographical scope. Ultimately, I decided to emphasise evidence that represented deeply personal turning points and transformative moments in Cousins's life rather than trying to represent the entire arc of his life and risk writing a tome.

Richard Holmes, who wrote *The Age of Wonder*,[19] a history of eighteenth-century scientists such as the botanist Joseph Banks, suggests: 'Science is always a story … a detective story, perhaps; a mystery story … but always a story of human lives.' Holmes believes contemporary readers long to learn 'what makes scientists tick and what set them ticking'. They are curious about what drives researchers to make discoveries, how they respond to failure and personal matters such as love and relationships. Readers perceive imaginatively written biographies as gripping, even *electrifying* 'adventures of the human spirit' despite the account being based on complicated medical or scientific information.[20]

[16] MJC, 'Curriculum Vitae for Professor Michael Cousins AO', April 2016, Cousins, Medical Biographies Collection, Royal North Shore Hospital Archive (hereafter RNSH Archive).

[17] Tom Hager, *Linus Pauling: And the Chemistry of Life* (New York: Oxford University Press, 2000).

[18] Tom Hager, 'The Bootlegger's Son: Or the Stochastic Method in Biography', The Life and Work of Linus Pauling (1901–1994): A Discourse on the Art of Biography, Oregon State University, 28 February 1995, https://scarc.library.oregonstate.edu/events/1995paulingconference/video-s2-2-hager.html.

[19] Holmes, *The Age of Wonder*, xvii.

[20] Holmes, 'The Scientist within', 499.

Holmes's comments gave me the confidence to write creatively, employing novelistic devices based on corroborated facts, such as reconstructing scenes, manipulating the pace and rhythm, creating conflict, building suspense and including dialogue. The development of a new method of pain relief by the Flinders researchers was a pivotal moment in Cousins's life and provided an opportunity for me to employ these devices in the following extract:

> The first patient they tested with this technique was a fifty-five-year-old woman named Dora who suffered from severe upper back pain following colon surgery. Early one evening, Dora lay on a bed in the recovery ward where a six-member research team had prepared her to receive an epidural injection of pethidine. Constantly wriggling on the bed to relieve her pain, she rated it as ten on a scale of one to ten. Two nurses scurried around tidying up before they left for the day while Mather stood beside Dora's right shoulder chatting with her about the procedure.
>
> Mather taped a thermometer around Dora's right big toe to measure any changes in her body temperature triggered by pethidine's local anaesthetic action. Then Cousins injected the analgesic via a catheter leading into the epidural space in her upper back. After observing Dora's facial expressions and body language for twenty minutes, he asked: 'How's your pain?'
>
> 'I don't have any pain', she said.
>
> 'Do your legs feel numb?'
>
> 'No. They feel normal.'
>
> He instructed Dora to wiggle her legs. She did.
>
> This response astounded the team members because the pethidine had not caused the loss of feeling or movement in the legs that occurred whenever they injected a local anaesthetic into a patient's epidural space. They postulated that the initial pain relief from high doses of epidural pethidine resulted from an analgesic action in the spinal cord.[21]
>
> During the following weeks, the Flinders investigators repeated the procedure on fifteen more patients, seven with postoperative pain and eight with intractable pain. In all patients, the onset of pain relief occurred within five minutes and was complete within thirty minutes. The researchers were ecstatic, realising an improved method of pain relief was seemingly within grasp![22]

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[21] Chris Glynn et al., 'Peridural Meperidine in Humans: Analgetic Response, Pharmacokinetics, and Transmission into CSF', *Survey of Anesthesiology* 26, no. 5 (1982): 520; Laurence Mather, interview by GKD, 16 April 2019.

[22] Kelly-Davies, 'Breaking through the Pain Barrier',168–169.

I reconstructed this scene from Cousins's memories and those of his Flinders colleagues, corroborating them by studying journal articles and textbooks on epidural analgesia. My aim was to translate a scientific study into an enthralling narrative that made readers *feel* as if they were in the recovery ward with the research team. The dialogue is paced to show Cousins's gradual realisation that the procedure, which is still considered seminal within pain medicine and anaesthesia circles,[23] was successful.

The intense intellectual energy, creativity, and personal conviction of many prominent scientists eclipses the norm, presenting biographers with a quandary—how to portray the truth when a subject's personal narrative might have a scientific or historical agenda? The historian Bernadette Bensaude-Vincent experienced this issue while writing the biography of physicist Paul Langevin.[24]

Bensaude-Vincent soon realised Langevin's conception of himself as a solitary genius was shared by his colleagues, supporters and the media. However, she aimed to characterise him more realistically.[25] This is one of the issues I faced because Cousins's own narrative of his life, and one which several family members, friends and colleagues shared, portrayed him as single-handedly building the field of pain medicine in Australia. The reality, though, is that he was supported by teams of talented pain professionals. After conceiving the idea for a study or strategy, he sourced funding, then delegated responsibility for progressing it to team members, many of whom viewed him as 'captain of the ship' and themselves as willing 'lieutenants'.[26]

Contextualising a Scientist's Life

The science historian Oren Harman suggests that biography is a valuable prism through which to evaluate ever-changing cultural mores and norms because the genre reflects 'notions of truth, objectivity and the role of science in society'.[27] Holmes agrees, claiming biographies of

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[23] Ted Shipton, 'Honouring a Giant in the Field of Pain Medicine. A Pain Medicine Perspective', *ANZCA Bulletin* (December 2016): 80–4.

[24] Bernadette Bensaude-Vincent, 'Paul Langevin: L'histoire Des Sciences Comme Remède à Tout Dogmatisme', *Revue D'Histoire Des Sciences* 58, No. 2 (July–December 2005): 311–27.

[25] Bernardette Bensaude-Vincent, 'Biographies as Mediators between Memory and History in Science', in *History and Poetics of Scientific Biography,* ed. Thomas Söderqvist (London: Routledge, 2007), 173.

[26] Milton Cohen, interview by GKD, 1 October 2019.

[27] Oren Harman, 'Scientific Biography', in *Handbook of the Historiography of Biology*, ed. R. Dietrich, M. E. Borrello and O. Harman (Switzerland: Springer, 2021), 291.

scientists fascinate contemporary readers because the stories bring research to life and illustrate the thrill of discovery. The best of these biographies, he asserts, reveal how research, social politics and historical context merge through an individual's lived experience.[28] A vital aspect of social politics, according to the historian E. P. Thompson, is conflict, especially when a subject attempts to change accepted practices.[29]

Conflict is also at the heart of engaging storytelling, and it was a recurring theme throughout Cousins's career. His single-mindedness and declarative rather than consultative approach also brought him into conflict with some colleagues, who claimed he was driven by ambition and self-interest. Ignorance about the personal and societal costs of chronic pain led him into many battles and, despite being conflict averse, 'always polite' and 'the consummate diplomat', according to his associates, he became an indomitable opponent through his experiences at FMC.

In 1975, when Cousins arrived at FMC, one of his priorities was building a world-class pain centre. From the start, however, he had to fight for funding, and the initial conviviality among department heads descended into fierce rivalry when they competed for resources. The following extracts illustrate the opposition he faced:

> Gus Fraenkel had recruited a team of young, extremely ambitious and, according to several Flinders Medical Centre (FMC) staff, 'manipulative' professors to head each department. At one meeting, an angry department head hissed: 'Over my dead body!' when Cousins outlined his plan to build a pain centre. Decades later he recalled:
>
> We were all great friends slapping each other on the back when we abutted on each other in the library. But when it came time for the cut and dice, it was every man for himself. I'd seen nothing quite like it. I was new at the game and still learning the ropes. I knew I needed to ramp up my efforts a hundredfold.[30]
>
> …
>
> Cousins recalled a contentious meeting with the hospital's department heads and senior managers late one Sunday afternoon, a month after he moved to Adelaide. Eight men, each jostling for dominance, sat around a large rectangular table debating funding submissions. It was stiflingly hot and humid. Towards the end of the fractious meeting, when everyone just wanted to return home and enjoy a cold beer, they

[28] Lucas Wittmann, 'The Art of Biography No. 7 Richard Holmes', *Paris Review*, 223 (Winter 2017): 148.

[29] E. P. Thompson, *Witness against the Beast: William Blake and the Moral Law* (Cambridge: Cambridge University Press, 1993), xii.

[30] Kelly-Davies, 'Breaking through the Pain Barrier', 136.

> reached Cousins's proposal, requesting financial support from the university and hospital to build a multidisciplinary pain centre. One of the more outspoken young professors snarled: 'Cousins, if you think you're going to walk out of this meeting with funding to set up a pain centre, you've got another thing coming.'[31]

Given the crucial role of historical context in shaping a subject's life, 'Breaking through the Pain Barrier' explores Cousins's experiences against the backdrop of mid-to-late-twentieth-century social, cultural and political norms, especially the dominance of white middle-class men in medicine and the professions, and the low priority accorded to pain management within the healthcare system. It also considers the impact of monumental social change during the 1970s, including the changing role of women in society, emergence of the consumer voice and growing expectations of a right to pain relief.

To track the sociopolitical dimensions of the pain medicine world in which Cousins operated, I studied interview transcripts, the pain medicine literature, minutes of meetings, correspondence, policy documents and media commentary. These sources reveal that pain medicine as a field of practice did not exist until after Melzack and Wall proposed the Gate Control Theory in 1965, and when it built momentum during the 1970s, many in the medical profession dismissed it.

A social, cultural and political issue affecting the way people living with chronic pain are perceived is stigma. Cousins often spoke about stigma and its consequences, as illustrated in the passages below:

> Australia urgently requires a public education campaign to promote understanding of chronic pain. People living with it are stigmatised as bludgers and copping out on their workmates.[32]
>
> …
>
> Declaring that everyone in the room shared a responsibility to those who experienced chronic pain, 'who are stigmatised, disbelieved, demoralised and grossly undertreated', he demanded that federal and state governments back a community-led program to destigmatise chronic pain. Recounting how people with chronic pain

[31] Kelly-Davies, 'Breaking through the Pain Barrier', 136–137.

[32] Jon Pierik, 'Management of Chronic Pain "Inadequate"', *AAP Bulletins*, 19 October 2009; Kelly-Davies, 'Breaking through the Pain Barrier', 262.

> faced discrimination, he contrasted their management to people with other chronic diseases. 'Addressing this situation is a moral imperative', he exhorted.[33]

These comments reveal the environment in which Cousins worked, one he resolved to transform, knowing it would bring him into conflict with hospital chiefs, politicians and the medical profession.

A Scientist's Quest

Settling on the structure for the published edition of *Breaking Through The Pain Barrier* involved six months of experimentation, as further explored in Chapter Four of this exegesis. The historian Mott Greene suggests biographers have traditionally structured science biographies as folkloric hero journeys.[34] Contemporary biographers, however, avoid portraying researchers as heroes or solitary geniuses because of the risk of hagiography and misrepresentation of the nature of scientific research. Teams of researchers, laboratory technicians and postgraduate students conduct experiments and write journal articles, so it is misleading to claim one individual is solely responsible for scientific discoveries.[35] Nevertheless, Greene's depiction of the hero's journey provides a creative structure for a scientific life, and it is the framework I chose because it enabled me to chronicle Cousins's journey from his early days studying pain medicine through to his retirement.

Greene explains that a biographer's task involves delivering a scientist 'from some unknown beginning point to a known significant endpoint', despite the 'villains'.[36] The following excerpt conveys Cousins's 'unknown beginning' after he treated two critically burned boys in 1964:

> Michael Cousins had felt 'out of his depth' trying to reduce the boys' suffering and realised his medical training had not equipped him to control such severe pain. 'I guess it impressed on me the need to have something a lot better', he recalled. Unsure how to specialise in pain, he asked the senior doctors at his hospital about it. Pain was such a new field of medicine that few people knew about it. His colleagues suggested he train as an anaesthetist because, in the 1960s, it was anaesthetists who treated

[33] MJC, 'Speech Notes: National Pain Summit', 11 March 2011, MJC Private Collection; Kelly-Davies, 'Breaking through the Pain Barrier', 263.

[34] Mott T. Greene, 'Writing Scientific Biography', *Journal of the History of Biology* 40, no. 4 (2007): 740.

[35] Thomas L Hankins, 'In Defence of Biography: The Use of Biography in the History of Science', *History of Science* 17, no. 1 (1979): 3.

[36] Greene, 'Writing Scientific Biography', 739.

> patients with excruciating pain. 'It didn't take me long to realise that to find the right spot for me in medicine, I needed to get onto the road of anaesthesia training.'
>
> In January 1965, six months after treating the burned boys, Cousins joined RNSH in northern Sydney as an anaesthesia registrar.[37]

From this unknown beginning, each chapter reveals the different stages of Cousins's quest, despite financial constraints, hostile opponents and systemic inertia. His struggles with inadequate funding dominated 'every waking moment' and kept him awake at night.

The next element, the core of a science biography, is the 'hero's quest'. The subject is 'tested, interrogated, attacked' and experiences disappointments such as failed experiments and dissent among the scientific community. By exploring a person's response to these problems, a biographer attempts to show their determination, tenacity and resilience.[38] The following passage reveals the criticism Cousins faced in pursuing his quest to have chronic pain accepted as a chronic disease. The setting is an international conference for anaesthetists and pain specialists. In his oration, he carefully laid out the emerging evidence that chronic pain could cause persistent physical effects within the nervous system:

> 'Pain receptors in the body can become sensitised by surgery or trauma, increasing the body's response to any noxious stimulus in the area of the pain.' He felt a shiver ripple through the audience. This was the beginning of his crusade to have chronic pain recognised as a chronic disease. His claim was an explicit challenge to the prevailing orthodoxy that pain was merely a symptom of an underlying injury or illness. It was a controversial position to take and divided the pain medicine community. Unperturbed, he persisted in the face of strident criticism.[39]

One of Cousins's RNSH colleagues, Charles Brooker, described his mentor's approach to opponents—'the villains':

> Whenever Michael couldn't achieve an acceptable outcome, he went over people's heads and rang someone more senior. He wasn't afraid to go around people, to a point the person he was talking to might be a little surprised he had gone above them, but they would admire his audacity. Once in front of a senior person, Michael would offer them an eminently reasonable arrangement. 'I think we can achieve this', he would

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[37] Kelly-Davies, 'Breaking through the Pain Barrier', 97.

[38] Greene, 'Writing Scientific Biography', 740.

[39] MJC, 'Pain: The Past, Present and Future of Anesthesiology? The E.A. Rovenstine Memorial Lecture', *Anesthesiology* 91 (1999): 551; Kelly-Davies, 'Breaking through the Pain Barrier', 237.

say. 'It'll be a little bit of cost here, but we can make it back, and the benefits will be X, Y and Z.'

> Brooker noticed Cousins always crafted a game plan to overcome roadblocks. 'Despite his intense frustration, Michael never lost his cool and he was always polite but doggedly persisted', Brooker said, adding:
>
> When something didn't go his way, he kept driving forward and brushed off disappointments. Struggling through some challenging times, he just gritted his teeth and marched on until he had accomplished whatever he was trying to achieve. He wasn't affected by other people's opinions of him, which probably helped him survive many turbulent months of hostile meetings.[40]

Next in the hero's quest is the acquisition and use of 'a magical agent', depicted by a 'technique, instrument or a new a conception arriving in the subject's mind'.[41] The following extract describes the Flinders's team's inspiration for conducting the seminal research study on epidural analgesia in 1979 that catapulted them onto the world stage in pain research:

> Inspired by the analgesia research of Tony Yaksh and his team at the Mayo Clinic in the United States, the investigators at Flinders Medical Centre (FMC) began a series of studies on epidural pain relief in the late 1970s. The Mayo scientists found that injecting morphine into the intrathecal space—the fluid-filled area between the innermost layer covering the spinal cord and the middle layer[42]—relieved pain.[43] In 1977, the anaesthetist Peter Wilson joined FMC from the Mayo Clinic, where he had worked alongside Yaksh. Soon after arriving at Flinders, he received one of the hospital's first research foundation awards for his project: 'Selective spinal analgesia by epidural administration of narcotics.'[44]
>
> In a break from the standard practice, FMC's researchers injected pethidine rather than morphine into the epidural space. Mather postulated that using pethidine instead of morphine might capitalise on the local anaesthetic action of pethidine to heighten its pain-relieving activity in the spinal cord. He thought any systemic effects of the larger dose used epidurally might augment any spinal action.[45]

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[40] Charles Brooker, interview by GKD, 13 August 2019; Kelly-Davies, 'Breaking through the Pain Barrier', 258.

[41] Greene, 'Writing Scientific Biography', 741.

[42] Harris, Nagy and Vardaxis, *Mosby's Dictionary of Medicine*, 923.

[43] Tony Yaksh and Thomas Rudy, 'Analgesia Mediated by a Direct Spinal Action of Narcotics', *Science*, 192, no. 4246 (June 1976): 1357–58.

[44] MJC, 'Minutes of the Thirteenth Meeting of the Division of Anaesthesia and Intensive Care, 13 June 1979', Box 15, Folder 3, Fraenkel Collection, 4.

[45] Mather, 'Stereopharmacological Research in Anaesthesiology', 32.; Kelly-Davies, 'Breaking through the Pain Barrier', 168.

As seen from the excerpts, the folkloric hero's journey structure enabled me to sequence the narrative around turning points and transformative moments in Cousins's quest and that of his equally dedicated colleagues to advance the treatment of pain.

Solitary Genius versus Group Biography

Science biographies are group biographies to some extent, Holmes suggests, and should be less about the 'dazzling idea of solitary genius' and more about teamwork and the social impact of discovery.[46] Holmes believes the progress of scientific experiments is like a relay race:

> Each person does a certain amount, they get certain things right, certain things wrong, they often don't know which is which. And then the work is passed on, so it's a group activity, a cumulative activity, and this requires a group biography, otherwise you'd distort the nature of scientific research.[47]

In some respects, 'Breaking through the Pain Barrier' might be considered as a group biography, because Cousins's achievements were largely enabled by the teams of colleagues he led who shared his vision. Caine, however, maintains that the focus of group biography is relationships within a group or their shared ideas and activities, rather than the lives of individuals within the group.[48] Nigel Hamilton and Hans Renders confirm this view, claiming that group biography dwells on the connections—direct, implicit or merely comparative—between individuals in a group.[49] Based on these criteria, Cousins's life story would not qualify as a group biography.

While reflecting on these ideas, I questioned to what extent Cousins's character, personality, and behaviour set him apart or whether he was just a product of his gender, upper-middle-class upbringing, and social norms in the second half of the twentieth century. Microhistorians ask this question, using individual lives and episodes from a life to illustrate larger historical and social patterns.[50]

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[46] Holmes, *The Age of Wonder,* xvii; Richard Holmes, *Footsteps: Adventures of a Romantic Biographer* (London: Vintage, 1996), 16.

[47] Wittmann, 'The Art of Biography No. 7 Richard Holmes', 149.

[48] Caine, *Biography and History*, 46.

[49] Nigel Hamilton and Hans Renders, *The ABC of Modern Biography* (Amsterdam: Amsterdam University Press, 2018), 65.

[50] Renders and De Haan, *Theoretical Discussions of Biography*, 105.

The field of microhistory and its relationship to biography is the subject of vigorous debate. Caine suggests that microhistorians set out to gain access to the inner life of individuals, 'the patterns of thought and belief, the emotions and the voices of ordinary people'.[51] Although microhistory and biography share many similarities, each is a distinct area of study. The historian Jill Lepore explains that microhistorians use a person's life to illustrate a historical pattern or development whereas biographers view their subjects as unique:

> If biography is largely founded on a belief in the singularity and the significance of an individual's life and his contribution to history, microhistory is founded upon almost the opposite assumption: however singular a person's life may be, the value of examining it lies not in its uniqueness, but in its exemplariness, in how that individual's life serves as an allegory for broader issues affecting the culture as a whole.[52]

Readers are curious about what a biographical subject was like, the scholar Caitríona Ní Dhúill attests, rather than who else they were like, which is the focus of microhistory. 'The focus of biography, by and large, is on the individual life *as an end in itself* rather than as a means to the end of sociohistorical analysis', Ní Dhúill remarks, suggesting that biographers use 'the archival traces of the subject's life' to reconstruct the story of a life, whereas microhistorians use biographical evidence 'as the entry point into broader social questions'.[53]

Renders and David Veltman describe a 'third wave' of microhistory studies that involve studying individual perspectives to gain new insights about general issues. 'Modern biographers should not seek confirmation of the representatives of the person under scrutiny', the two scholars explain. 'Instead, they are capable to show discrepancies in the agency of the individual between a micro and macro level.'[54]

Cousins's story provides a snapshot of the history of pain medicine in Australia from the 1960s onwards through his eyes and those of his colleagues. Though I interviewed most of the individuals who collaborated to build the field of pain medicine in Australia during the 1970s–2000s, 'Breaking through the Pain Barrier' is not an exhaustive history due to space

[51] Caine, *Biography and History*, 108.

[52] Jill Lepore, 'Historians Who Love Too Much: Reflections on Microhistory and Biography', *Journal of American History* 88, no. 1 (2001): 132–33.

[53] Caitríona Ní Dhúill, *Metabiography*, Palgrave Studies in Life Writing, (Switzerland: Palgrave Macmillan, 2020), 100.

[54] Hans Renders and David Veltman, 'The Representativeness of a Reputation: A "Third Wave" in Microhistory', in *Fear of Theory*, ed. Hans Renders and David Veltman (The Netherlands: Brill, 2021), 192.

restrictions. Vitally, Cousins's biography fits into a broader genre of medical history as a narrative of social, scientific and medical progress and mirrors the experience of many other doctors driven by a vision to improve clinical practice.

Perhaps critics might dismiss the book, claiming it represents a Thomas Carlyle 'Great Man' or hero theory of biography, a continuation of the genre's historic gender asymmetry?[55] Yes, Cousins was a product of a white, upper-middle-class family and his career spanned the second half of the twentieth century when men dominated medicine and the professions. His gender, affluence, social position and the patriarchal society into which he was born all assisted him to achieve his goals. Male role models and mentors profoundly influenced him, and he harnessed the support of his predominantly male connections to advance his cause. Vitally, his wife Michele's unwavering support enabled him to focus on professional responsibilities while she managed their home, garden, social life and raised their four surviving children, often on her own.

Nevertheless, while Cousins enjoyed many advantages, it is crucial to acknowledge how he used his privilege to advance the treatment of pain despite the many sacrifices it forced on him and his family. This, however, raises a question about his right to expect Michele and his children to accept the way his career dominated their lives, a question explored in Chapter Two of this exegesis.

Ní Dhúill suggests that biography is a double quest, involving both the biographer's quest to uncover the truth of a subject and the subject's quest.[56] This was certainly true for me. One aspect of my quest was understanding the driving force behind Cousins's crusade to improve the treatment of pain. Why did he pursue his five-decade campaign when it took such an immense toll on him and his family? This question will be explored in the next chapter, which considers how I attempted to reconcile his conflicting personas and create a multidimensional biographical portrait.

[55] Melanie Nolan, *Biography: An Historiography* (New York: Taylor & Francis, 2023), 5.

[56] Dhúill, *Metabiography*, 27.

Chapter Two: Crafting a Kaleidoscopic Biographical Portrait

Reconciling the scientific, professional and private realms of Cousins's life and preventing his career from overpowering his human story was problematic. A reserved person, he preferred speaking about his public rather than his personal life, so one of my challenges was encouraging him to discuss matters he considered intimate to enable me to create a kaleidoscopic rather than a one-dimensional portrait.

George Sarton, who founded the discipline of the history of science as an independent field of study, strengthened my resolve to persevere with crafting a balanced profile. 'The history of science and, in particular, the history of medicine is not simply an account of discoveries', Sarton pronounced in 1941. 'It is the historian's main duty to revive the personalities rather than to enumerate their scientific discoveries. Discoveries may be important, but personalities are infinitely more so.'[1]

Initially, I planned to accord equal weight to Cousins's professional and private lives. However, after much experimentation, I realised this was unrealistic because his career dominated his life and that of his family. After much deliberation, I decided to create parallel narratives within each chapter, interweaving pain medicine responsibilities with reconstructed scenes with Michele and his four surviving children.

To learn how other writers resolved this issue, I studied several biographies of prominent doctors and scientists. Among them were Charlotte Jacobs's *Jonas Salk: A Life,*[2] the biography of the virologist who developed the polio vaccine; Catherine Reef's biography of the nurse Florence Nightingale;[3] Rayvon Fouché's *Black Inventors in the Age of Segregation*;[4] and Kai Bird and Martin J. Sherwin's *American Prometheus: The Triumph and Tragedy of J. Robert Oppenheimer*,[5] to name a few.

[1] George Sarton, 'Fielding H. Garrison Lecture', published in *Bulletin of the History of Medicine* 10 (1941): 123–35.

[2] Jacobs, *Jonas Salk: A Life*.

[3] Catherine Reef, *Florence Nightingale: The Courageous Life of the Legendary Nurse* (Boston: Houghton Mifflin Harcourt, 2016).

[4] Fouché, *Black Inventors*.

[5] Bird and Sherwin, *American Prometheus.*

A biography is not a chronicle of events, Charlotte Jacobs insisted in a workshop on science biography, and a biographer's task is to portray the vital speaker: 'What's the intellectual, the spiritual, the moral concept of the makeup of the person, and how does it evolve with time?' Jacobs admitted this was challenging for her because Salk was intensely private. He rarely dropped his protective shield, making it difficult for her to comprehend his paradoxes and some of the complex questions about his life.[6]

One of a biographer's roles is to select and organise episodes of a subject's life that reflect character and personality traits and values, asserts Oxford University's Centre for Life Writing co-director, Kate Kennedy. 'Subtle differences exist between character and personality, yet it can be difficult to distinguish between the two.'[7]

A person's fundamental or core driving principles constitute their character. Character traits are consistent throughout a person's life and include tenacity, resilience, self-belief and courage. 'Character is ethically valuable', Kennedy said, 'because it reflects a high level of self-control and autonomy. From the perspective of others, having character means that you are reliable in a manner that is deliberate or reflectively endorsed.' Kennedy maintains that this reliability lends a degree of trustworthiness to a person's character that even robust personality traits cannot match. Unlike personality, if certain pressures cause an individual to behave in certain ways, becoming aware of these pressures should motivate someone with character to manage the pressures in a way that is in accordance with their values. 'To count as character development, such changes must follow from a process of self-reflection and not simply a compelling influence like a traumatic incident.'[8]

In contrast, personality traits can change over the course of a person's life depending on their experiences and environmental pressures, so while a person might be bubbly, gregarious and outgoing as a child, traumatic events could make them withdrawn and sombre as an adult.[9]

In creating multidimensional representations of three African American inventors from the late nineteenth and early twentieth centuries—Granville T. Woods, Lewis H. Latimer and Shelby

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[6] Charlotte Jacobs, *Biography of Science, Medicine and Innovation*, BIO Virtual Workshop, 6 March 2021, https://www.youtube.com/watch?v=OWO_tBWcnpg.

[7] Kate Kennedy, interview by Gabriella Kelly-Davies (hereafter GKD), 29 May 2024.

[8] Kate Kennedy, interview.

[9] Kennedy, interview.

J. Davidson—Rayvon Fouché strove to open their lives to a more thoughtful reading. 'Just because people work in technical, scientific or medical spaces doesn't mean they don't live outside of that world as well', he remarked. 'Sometimes that part of their lives is just as interesting as the technical work. It's impossible to extract the scientific technical work from the human story.'[10] Holmes agrees, advising biographers to ask: 'What was this human life really like, and what does it mean to us now?'[11]

This chapter examines my choices as I strove to portray the conflicting spheres of Cousins's life and craft a nuanced biographical portrait. These choices fall into three broad categories: transcending the public image, portraying the interior life and reconciling opposing views.

Transcending the Public Image

David Marr, who wrote the biography of Australian author Patrick White,[12] believes the 'potency of biography is its compelling intimacy'.[13] To achieve this level of connectedness, Hermione Lee encourages biographers 'to get behind the public performance and show us the real person at home in his undress'.[14] I questioned to what extent this is possible, because a subject can maintain their public persona at home during interviews with a prying biographer, which was my experience.

During 2019 and before COVID-19 lockdowns arrived in 2020, I interviewed Cousins every week in his home. These visits enabled me to observe his interactions with Michele, revealing much about his capacity to love and his loyalty and devotion to those close to him. Frustratingly, he often shared the same legendary stories he had told to a succession of oral historians and journalists—his version of the narrative of his life. Whenever my questions strayed too far into matters such as private thoughts that Cousins considered too personal, he quickly steered the conversation to safer territory; I despaired of ever penetrating his protective shell. A comment by biographer Stacy Schiff, however, reassured me: 'Biographers have the

[10] Fouché, *Biography of Science.*

[11] Richard Holmes, *This Long Pursuit: Reflections of a Romantic Biographer* (London: Vintage, 2017), 17.

[12] David Marr, *Patrick White: A Life* (North Sydney: Random House Australia, 2008).

[13] David Marr, 'The Art of Biography: The Author Stays out of the Picture, and Other Personal Rules of Writing', *Monthly* (December 2016 – January 2017): 2.

[14] Hermione Lee, *Biography: A Very Short Introduction* (New York: Oxford University Press, 2009), 4–5.

luxury of time to get to know people and win their trust.'[15] Schiff maintained that, eventually, subjects will respond to uncomfortable questions. Over the course of eighteen months, I reframed and repeated the questions Cousins had deflected in earlier interviews, waiting until he was willing to answer them.

Despite my best efforts, some questions remained unanswered, especially feelings and emotional responses to various situations. To address this issue, I searched for other ways of accessing this information, including in letters Cousins wrote and received, and by interviewing a multiplicity of individuals from each sphere of his life. Presenting Michele's point of view and that of the couple's twins, Jane and Chris, was also crucial, particularly in understanding how Cousins's choices affected them. Yet Michele brushed aside my questions whenever I asked her about the sacrifices her husband's career forced on her and their children. 'I knew what I was signing up for in marrying a doctor', she quipped.[16] The following passage illustrates some of these impacts:

> Michele baulked at the idea of moving to Adelaide so soon after returning from America, and she felt heartbroken to be leaving her family and friends again. At the same time, she enjoyed being her husband's confidante; he often consulted her on crucial work-related decisions and respected her opinion. She knew he leaned on her to keep his home life running smoothly and to help him advance his career, though she had anticipated it before they married and willingly accepted it. A committed homemaker whose top priorities were supporting her husband and raising healthy, happy children, she loved her critical role in supporting his quest.[17]

In each chapter, I weaved reconstructed scenes of family life into the narrative that reveal how Cousins interacted with his family and how they perceived him. The first extract shows him at home with Michele and his children when they lived in Adelaide in the late 1970s, and the second passage is based on life in Sydney during the 1990s:

> Most nights at bedtime, Cousins invented magical tales for his children about the adventures of a rubber horse who 'flew all over the place'; his children still remember these stories with nostalgia. After tucking them into bed and kissing them good night, he either returned to his office at the hospital or headed to Highfield's basement study for a few hours of research and writing. Michele usually joined him in the study

[15] Ruth Franklin, 'The Art of Biography No. 6 Stacy Schiff', *Paris Review* (Winter 2017): 43.

[16] Michele Cousins, interview by GKD, 23 August 2019.

[17] Michele Cousins, interview by GKD, 23 August 2019; Kelly-Davies, 'Breaking through the Pain Barrier', 134.

> because she was copyediting the textbook on pain and regional anaesthesia he was co-editing with Bridenbaugh.[18]
>
> …
>
> Meanwhile, Jonathan, Chris and Jane were growing up, and life at home was hectic. Michele acted as the primary disciplinarian because she spent so much time with the children, and Cousins served as the family's peacemaker. Jane recalls that whenever a dispute arose, her father would patiently listen to everyone's point of view then find a 'fair solution'.[19]
>
> Chris described his father as a 'warm, loving, calming force' in the household, firm rather than strict. 'Dad taught us values such as honesty, kindness and looking after people.' The boys also learned 'olde-worlde manners' from their father, such as pulling out dining chairs and opening car doors for women.[20] If Cousins's children had an issue they could not resolve, he would sit with them, draw up a pros and cons list, and suggest how to solve the problem logically. 'Don't sweat the small stuff' was a favourite piece of advice, and whenever his children worked on a project, he told them to 'Remember the Five Ps', the formula for success his father, Hedley, had taught him.[21]

Portraying the Interior Life

Accessing and representing Cousins's interior life was challenging because he was so reserved. Given the vital role of private thoughts, emotions and fantasies in revealing a subject's psychological complexity, I was eager to understand his inner life. However, a biographer's expectation of accessing a subject's interiority is a contested issue.[22] I questioned to what extent an author should expect to access a subject's innermost realms, recognising that it is one of the ethical and privacy issues facing biographers, especially for a living subject. Chapter Three of this exegesis explores this topic in more detail.

Hermione Lee suggests that a biographer's deep knowledge of a subject gives them a sense of the person, their thoughts and even their secrets.[23] Holmes concurs, maintaining that patterns materialise during the research process and people's personalities emerge over time 'in the way

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[18] Kelly-Davies, 'Breaking through the Pain Barrier', 166.

[19] Jane Cousins, interview by GKD, 6 May 2020; Kelly-Davies, 'Breaking through the Pain Barrier', 220.

[20] Chris Cousins, interview by GKD, 25 May 2020.

[21] Jane Cousins, interview; Chris Cousins, interview; Kelly-Davies, 'Breaking through the Pain Barrier', 220.

[22] Paula Backscheider, *Reflections on Biography* (South Carolina: CreateSpace Independent Publishing Platform, 2013), 110–12; Nolan, *Biography: An Historiography*, 156–57.

[23] Louisa Thomas, 'The Art of Biography No. 4 Hermione Lee', *Paris Review*, no. 205 (2013): 144–45.

they act or do not act, understand or do not understand. Above all, how they love and imagine, including those fantasies, ambitions and inventions which never come to pass.'[24]

While wrestling with questions about Cousins's inner life and whether I had a right or obligation to readers to access and interpret it, I read an article by psychologist Douglas LaBier that helped me grasp this intangible concept. For LaBier, signs of a 'successful' inner life are an individual's values and clarity about their life purpose. Their level of self-control and resilience are also vital clues, as are emotional responses and the capacity to love.[25]

Although Cousins's persona and behaviour differed in each sphere of his life, his deep commitment to ethical principles, social justice and human rights were unifying themes. He internalised his parents' values, as reflected in the following passage:

> Personable and kind, Hedley was not religious, instead living by a high moral code he would instil in Cousins. Marjorie, Hedley and several members of their extended family lived with a strong moral compass, and they served as role models for the young Cousins, whose upbringing was conservative, conventional and upper middle class. Even as a young child, he had a strong sense of right and wrong and would admonish Geoff if he believed his younger brother's behaviour was 'out of line'.[26]
>
> …
>
> [Marjorie] was also active in the community and was known locally as a 'change agent'. Her ability to identify an issue, take action with confidence and conviction, and bring about change was a trait shared by others in Cousins's extended family, and it was deeply ingrained in him from an early age. The self-belief and confidence he exuded from childhood would be a hallmark of his character throughout his life.[27]

Cousins demonstrated a clarity of purpose in how he single-mindedly pursued his vision to advance pain medicine despite seemingly insurmountable obstacles. I gained insights into his interiority by reflecting on his intransigence, tenacity and resilience in the face of failure. His legendary political savvy also provided crucial clues. The following extract reveals these characteristics when a colleague asked him for some tips on negotiating:

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[24] Wittmann, 'The Art of Biography No. 7 Richard Holmes', 143.

[25] Douglas LaBier, 'Building an inside-out Life—The True Balance Is between Your Inner and Outer Life', *Psychology Today*, 8 June 2010, https://www.psychologytoday.com/us/blog/the-new-resilience/201006/building-inside-out-life-part-1.

[26] Fergus Ryan, interview by GKD, 28 May 2020; Ray Chapman, interview by GKD, 28 May 2020; Geoff Cousins, interview by GKD, 25 September 2019; Kelly-Davies, 'Breaking through the Pain Barrier', 100.

[27] Chapman, interview; Ryan, interview; Kelly-Davies, 'Breaking through the Pain Barrier', 100.

> 'Discuss nothing specific at a meeting', Cousins advised. 'Try to come out of it without agreeing to anything, then negotiate in the background later.' He explained that his approach was to arrive ready to confirm an agreement he had already negotiated because he believed it was impossible to get a controversial topic sorted out in your favour in a meeting. 'Ensure you nail down everything before a meeting. If you haven't settled an agreement beforehand, it's best to go in, grit your teeth, and get out conceding nothing', he added.[28]

One of Cousins's striking characteristics was the way he compartmentalised his life. When dealing with hospital bureaucrats, politicians and the medical profession, he was forthright, a tough negotiator and fiercely determined to achieve his goals. Yet, with his family, friends, inner circle and patients, he was warm, kind and empathetic. The following passage demonstrates aspects of his professional persona at the beginning of his IASP presidency:

> Outlining an ambitious agenda, he reiterated his determination to increase IASP's focus on acute pain and high expectations of council members to serve on committees. To ensure committee members 'pulled their weight', he urged committee chairs to provide him with a report on the contribution of each member 'so a rational decision to terminate or continue the individual's participation could be made'.[29]
>
> Cousins's president's address, which was published in the August 1987 edition of IASP's newsletter, emphasised his intentions in relation to acute pain: '<u>I would like to state quite firmly that IASP regards acute pain as being at least an equal priority to chronic pain</u>.'[30] He wanted the bold underlining to make clear his intention to 'shake things up'. In an oral history interview a decade later, he said: 'If people didn't like it, it was tough.'[31]

In 1990, Roger Vanderfield, RNSH's medical superintendent, approached Cousins about building an interdisciplinary pain centre at the hospital. The Northern Sydney Area Health Service's chief, Stuart Spring, conducted the negotiations. Cousins's approach to bargaining is evident in the following extract:

> Spring said Cousins was one of the most challenging negotiators he had ever encountered. 'Michael Cousins was an expert in driving a bargain', Spring stated. 'He never got angry, always took the high moral ground, and never let you feel you'd agreed at any point in the discussion. And he would often come back with something more after you thought you'd nailed a deal.' This 'something more' included

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[28] Brooker, interview; Kelly-Davies, 'Breaking through the Pain Barrier', 257.

[29] Kelly-Davies, 'Breaking through the Pain Barrier', 205.

[30] MJC, 'Incoming IASP President's Message', *IASP Newsletter* (August 1987), IASP Private Collection (original emphasis); Kelly-Davies, 'Breaking through the Pain Barrier', 205.

[31] MJC, interview by M. Meldrum, 32; Kelly-Davies ,'Breaking through the Pain Barrier', 205.

> seemingly endless lists of explicit clarifications and requests.[32] 'Michael was determined to get the best deal for pain management', Spring recalled.[33]

By contrast, Cousins's behaviour with his family and friends was intensely loving and gentle. While I knew from experience he would ignore or deflect questions about matters he considered private, I learned about them by paying close attention to his speech patterns, facial expressions and body language during our conversations. His intense grief was evident in his physical appearance, the pitch of his voice and emotional responses when I mentioned his son Richard, who died of viral myocarditis at the age of eight. The following excerpt illustrates his inner turmoil:

> Engulfed by grief, Cousins felt an overwhelming guilt that he had been working rather than at home to care for his beloved son. Geoff Cousins flew to Adelaide as soon as he heard the news, and he helped his older brother and Michele to organise Richard's funeral. Cousins was so distraught that Geoff worried he would never recover; even later in life, Cousins found it too distressing to speak about his son's passing.
>
> Cousins took bereavement leave for a few weeks and he cancelled a myriad of commitments. Heartbroken and desolate, his only source of solace was spending time with Michele, James and Jonathan. Once he returned to FMC, he was intensely withdrawn and 'dragged himself around the hospital' rather than his usual habit of sprinting along the corridors. No longer did he arrive in his office at six o'clock in the morning or return at night after dinner with his family, and for several months, he lacked the confidence to anaesthetise patients in the operating theatres.[34]
>
> His immense sorrow was palpable throughout the hospital and shared by his colleagues, who longed to lift the burden from his shoulders. 'For the professor of anaesthesia and intensive care to lose his son under those conditions was devastating for us all', Gourlay recollected. 'It took a long time, understandably, most understandably, for him to reintegrate into the department. He did what he had to do, often disappearing to collect himself.'[35]

Cousins often expressed his love for colleagues in his inner circle. Well before dawn on 14 August 1994, his telephone rang. It was his principal mentor and close friend, John Bonica.

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[32] Stuart Spring to MJC, 9 May 1990, Cousins, Michael, Medical Biographies Collection (hereafter Cousins, Medical Biographies Collection).

[33] S. Spring, interview by GKD, 24 April 2020; Kelly-Davies, 'Breaking through the Pain Barrier', 216.

[34] Josephine O'Grady, interview by GKD, 22 September 2023.

[35] Geoff Gourlay, interview by GKD, 15 February 2023; Kelly-Davies, 'Breaking through the Pain Barrier', 183.

> 'I'm dying, son', the older man announced, his usually dominant voice sounding soft and shaky.
>
> 'I'll jump onto the next flight to America to say goodbye to you in person', Cousins suggested.
>
> 'It's too late', Bonica whispered. 'I will die tomorrow. Michael, my friend, it's been good knowing you.'[36]

When I interviewed ten of Cousins's patients, their comments about him were remarkably consistent, as illustrated in the following quotes by Symantha Liu:

> Symantha appreciated Cousins's approach, which was to treat her with dignity, giving her the courage to keep trying. She was overwhelmed by his kind and caring manner and ability to really 'listen' to her.[37]
>
> Symantha's most vivid memory of Cousins involves a hospital ward and a tuxedo. She had been suffering with a cluster migraine for several days when the pain became unbearable. Cousins admitted her to RNSH. As she became increasingly distraught, Symantha felt a gentle hand on her shoulder and heard a soft voice say: 'Sam, it's me, Michael Cousins.'
>
> Through her tear-stained eyes and blotchy vision, she struggled to make him out. Slowly, a man wearing a dashing dinner jacket and with dapper silver hair came into view.
>
> Cousins told Symantha he was beside her and not to worry. She asked him why the hospital had disturbed him if he had somewhere important to be.
>
> 'Whenever I feel one of my patients has reached a migraine crisis, I can only feel better if I lay eyes on them for my own peace of mind', he said.
>
> Symantha said this is the 'measure of the man. For me, forever, a saint on earth.'[38]

The oncologist Fran Boyle, a colleague and patient of Cousins, shared this view, as illustrated in the following extract:

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[36] Kelly-Davies, 'Breaking through the Pain Barrier', 226.

[37] Kelly-Davies, 'Breaking through the Pain Barrier', 229.

[38] Symantha Liu, interview by GKD, 19 May 2020; Kelly-Davies, 'Breaking through the Pain Barrier', 281.

> As her pain specialist, Cousins was 'very gentle and lovely and explained things well', she recalled. 'Michael was passionate about patient care and training the pain fellows.'[39]

Cousins's colleagues also remarked on his attitude to patients. Tom Reeve, RNSH's inaugural head of surgery, said one reason he was drawn to Cousins as an anaesthesia registrar was his intense empathy for patients.[40] Marc Russo, a specialist pain medicine physician, was one of the medical students at the hospital when Cousins returned in 1990. Russo recalled Cousins's kindness and compassion. 'I remember his gentleness with the patients, and that's not something I saw necessarily every day, especially from many other professors', he said. 'During ward rounds, he exuded calmness and confidence and spent time with his patients.'[41]

Another aspect of Cousins's inner life is evident in the way he deliberated over life-changing decisions. He created an exhaustive list of alternatives, 'pros and cons', then painstakingly analysed them, the only exception being his decision to marry Michele, which, he declared, 'was never a decision because I knew she was the right one from the moment I met her'.[42] During 1973, after one year at McGill and another at Stanford, Cousins was invited to extend his appointment at Stanford. The following extract is an example of how he approached such major decisions:

> The couple discussed the opportunity late into every night for a week. Deeply conflicted, Cousins felt privileged to have learned from the pain world's leaders, and he was eager to consolidate his learnings at Stanford. Yet he also wanted to 'repay' the University of Sydney for its travel fellowship by returning to practise pain medicine in Australia. Remaining at Stanford was tempting because, as director of the veterans' pain unit, he treated patients who lived with chronic pain. He was also conducting studies on acute pain after surgery. The balance was overwhelmingly in favour of staying at Stanford because opportunities for academic research in anaesthesia were 'virtually nil' in Australia.
>
> Nonetheless, they felt the powerful tug of home. 'A little bell rings in the breasts of Australians when they are away from their motherland', Cousins stated. 'Eventually, it becomes too strong to ignore.' In the end, they decided to return to Australia so they could spend time with their ageing parents. They also wanted their children to grow up in Australia, close to their grandparents and cousins.[43]

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[39] Boyle, Fran, interview by GKD, 12 January 2024. Kelly-Davies, 'Breaking through the Pain Barrier', 222.
[40] Tom Reeve, interview by GKD, 28 September 2022.

[41] Marc Russo, interview by GKD, 17 January 2021.

[42] MJC, interview with Gabriella Kelly-Davies. 27 February 2019; Kelly-Davies, 'Breaking through the Pain Barrier', 106.

[43] Kelly-Davies, 'Breaking through the Pain Barrier', 128.

Although Cousins deflected questions about 'personal matters', the above extracts demonstrate aspects of his interiority I was able to glean through close observation, analysis of correspondence, minutes of meetings, speeches and media coverage, and interviews with a range of individuals.

Reconciling Opposing Views

Two extreme views of Cousins emerged during interviews with pain medicine professionals, family and friends. His superiors and mentors, such as John Bonica, Phillip Bromage, Ronald Melzack and Patrick Wall, praised him, asserting that early in his career he displayed a remarkable combination of skills as a clinician, researcher and leader. They also noted his enthusiasm, innovation and tendency to collaborate within a team, adding that he enjoyed a close rapport with everyone, including junior colleagues and medical students. John Loeser, Daniel Carr and Kathleen Foley, the colleagues he collaborated with from the early 1970s, eulogised him. Frustratingly, they ignored or deflected my questions about his human frailties and appeared intent on perpetuating the celebratory heroic narrative.

In contrast, a few of Cousins's peers at pain centres they led in Australia, especially those in Sydney, were less effusive. Two of them declined my interview requests, claiming Cousins was driven by self-interest, one adding: 'I have nothing more to say.' Others were more gracious, even though I knew they shared a tense professional relationship.

Interestingly, the next generation of Australian and overseas colleagues, many of whom Cousins had trained and mentored, expressed their admiration for him; they were reluctant to criticise him or tarnish his reputation. Several remain in awe of him.

Early in the research process, I learned that David Cherry, who headed FMC's pain clinic during the 1980s, had clashed with Cousins, so I was eager to interview him because dissenters can reveal much about the character and behaviour of a subject. For over two years, I relentlessly searched for him by speaking with his former colleagues, Googling, contacting ANZCA and sending multiple emails. Frustratingly, my search was fruitless, and I published the book without speaking with Cherry, which troubled me because I was eager to understand the source of their conflict.

During 2022, I continued my search and, one day while Googling, I found an article announcing Cherry had won a major golfing championship. I emailed his golf club in Adelaide, and the

administrator contacted him on my behalf. Much to my delight, he agreed to speak with me. He also sent me the email address of Geoff Gourlay, another FMC colleague, whom I also interviewed. Although Gourlay was critical of certain aspects of Cousins's behaviour, his remarks were more balanced than those of Cherry.

In 1978, Chris Glynn collaborated with Cousins to launch the Australian Pain Society (APS). Eager to interview him about this initiative, I spent four frustrating years searching for him. I knew Glynn had worked at Oxford University's teaching hospital, and in December 2022, I found an Oxford University email address on a PowerPoint slide Cousins had given me. I sent an email, asking the recipient if she knew Glynn's contact details. The woman replied, suggesting two potential email addresses and the contact details of two former colleagues. After a frantic round of emails, phone calls, 'missed calls' and voicemail at midnight on 5 December 2022, I finally found Glynn. I had assumed he and Cousins enjoyed a harmonious relationship, but to my astonishment, his remarks about Cousins were venomous.

Cherry and Glynn's vitriol after a forty-year gap surprised me, and I was unsure how to reconcile their views with the overwhelming weight of evidence, which was so positive. While it was crucial to understand the source of conflict and to represent the critics' views fairly, it was also essential to verify the allegations and not allow the biography to be used as a form of retribution. After I interviewed Cherry, Gourlay and Glynn, I presented their assertions to the colleagues I had previously interviewed and asked for their understanding of the disputes. The following excerpts demonstrate how I tried to reconcile conflicting views of Cousins:

> [Kathie] Knights observed an extraordinarily intense level of competition at FMC, 'even within the same room', because of the highly ambitious and often aggressive young department heads Fraenkel had recruited and the chronic scarcity of resources.[44] When asked about his competitive streak, Cousins insisted his attitude was 'gentlemanly' and never a 'winner takes all' approach.[45] The majority of his colleagues and those close to him agree; however, Glynn, Cherry and Gourlay, disagree, claiming that he 'passed off' their ideas as his own and did not acknowledge their contributions, especially in conference papers.[46]

[44] Kathie Knights, interview by GKD, 28 August 2023.

[45] MJC, interview by GKD, 7 July 2019.

[46] Glynn, interview; Cherry, interview; Gourlay, interview. Louisa Jones challenged these claims. 'Michael had a lot of his own ideas; he didn't need to borrow other people's ideas.' Jones, interview. Reeve agreed. One of the things he had first noticed about Cousins and something he believed distinguished him from his colleagues, was his frequent habit of suggesting innovative ideas for research, so much so Reeve labelled his younger colleague an 'ideas man'. Reeve, interview.

‘What Michael said and did didn’t always match what he thought he was going to do’, Gourlay explained:

> He was a bit tricky. As the senior person in our department, he viewed all the research as his. It was his team, and he owned its research. Michael did what benefited Michael, and if your goals and his aligned, all well and good, and you got reflective glory from him. He supported team members who shared his vision and work ethic, and he went to great lengths to source research grants for them. It was a symbiotic relationship.

Nonetheless, Gourlay admitted Cousins had ‘a lot of very positive and admirable qualities’. When Gourlay disagreed with something Cousins did or said, he would confront him. ‘And that, to be honest, didn’t happen a lot’, he stated. ‘It could have happened a lot, but it didn’t. On the occasions it did, he would take it on the chin, and we’d move on.’[47]

In a December 2022 interview, Glynn claimed that Cousins had placed himself as the first author of a seminal journal article (published in the 1980s) that Cousins had promised to him. Four decades later, Glynn still held this grudge and his remarks about Cousins were venomous.[48] Equally disparaging was Cherry, who alleged that Cousins was the first author on papers when he had not led the research study, written the paper or made a significant contribution other than securing financial support.[49] This is a common source of conflict within academia and a vexed issue because of the group nature of scientific research, fierce competition for recognition in academic circles and the centrality of publications in gaining promotion to senior positions.[50]

Mather, Knights and even Gourlay insisted they never experienced an issue with Cousins about attribution of authorship.[51] So did numerous former doctoral students and a raft of colleagues throughout Cousins’s five-decade career. ‘Quite honestly, I never had any problem whatsoever with Michael about attribution of authorship or acknowledgment of my contributions’, Peter Brownridge attested.[52]

…

‘The important point’, Mather explained forty years later, ‘is that Michael’s innovation was to secure endless research grants for the postgraduate students and scientists in a bleak financial environment and nurture an environment where

[47] Gourlay, interview; Kelly-Davies, ‘Breaking through the Pain Barrier’, 176–177.

[48] Glynn, interview.

[49] Cherry, interview.

[50] Several editorials and letters in *Nature* and other science journals debated this issue. Anonymous, ‘Games People Play with Authors’ Names’, *Nature* 387, no. 6636 (26 June 1997): 831; William F. Laurence, ‘Second Thoughts on Who Goes Where in Author List’, *Nature* 442, no. 7098 (6 July 2006): 26.

[51] Laurence Mather, interview by GKD, 21 March 2023; Knights, interview; 16 November 2023; Gourlay, interview.

[52] Brownridge, interview; ‘Breaking through the Pain Barrier’, 177.

> scientists and clinicians collaborated on studies. He was determined to make HIS department prominent, both nationally and internationally, just like the Bonica model.' Mather believed strong egos and personal ambitions within the department fostered resentments and some individuals clashed with Cousins, believing they deserved more of the accolades he received.[53]

Other colleagues believe the discord resulted from rivalry and professional jealousy.[54] Pam Macintyre, director of the acute pain service at Royal Adelaide Hospital and an APS leader, admitted Cousins put some colleagues 'offside' by being single-minded and driving his own agenda rather than being truly consultative, as illustrated in the following extract:

> 'Over the years, Michael Cousins had his detractors who thought he was too big for his boots and self-promoting, but he was the one with the get-up-and-go. He got things going', she said.[55]

The way I reconciled conflicting opinions of Cousins was by presenting the opposing points of view and leaving it to the reader to draw their own conclusions based on the weight of evidence.

In conclusion, my key learning from this chapter is the criticality of balancing the various dimensions of a subject's life to create a kaleidoscopic rather than a one-dimensional portrait. An aspect of this is reconciling evidence about a person from a diverse range of sources to reflect their psychological complexity and contradictions. This can be particularly difficult when writing about a living subject, the focus of the next chapter.

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[53] Mather, interview by GKD, 19 September 2023; Kelly-Davies, 'Breaking through the Pain Barrier', 178-179.

[54] Brownridge, interview; Josephine O'Grady, interview by GKD, 22 September 2023; Mather, interview by GKD, 19 September 2023.

[55] Pam Mcintyre, interview by GKD, 3 October 2019; Kelly-Davies, 'Breaking through the Pain Barrier', 241–242.

Chapter Three: A Living Subject

'A dead man does not bite',[1] Plutarch wrote 1,800 years ago. Many others agree, including Jacqueline Kent, who wrote the biography of Julia Gillard, Australia's first female prime minister.[2] Kent maintains the ideal subject for a biography is someone 'who is not only dead but has no family'.[3] Hermione Lee concurs, admitting that until she wrote *Tom Stoppard: A Life*,[4] 'all my biographical subjects were safely dead'.[5] Nevertheless, I appreciated the immediacy of interviewing a living subject and the ability to explore ambiguities, contradictions and inconsistencies with him and his associates, recognising that writing about the living can be perilous.

This chapter examines the benefits and perils of writing about the living. It explores the merits and risks of authorised versus unauthorised biography and the imperative to avoid hagiography and serving as the subject's ventriloquist. It also considers the unreliability of human memory and ethical issues arising from revealing secrets and anything embarrassing or hurtful to a living subject or their family.

Dead or Alive?

Writing about a living subject has many advantages and I enjoyed visiting Cousins in his home every week. He was more relaxed there than at RNSH, though he was still always on guard. We sat at the family's mahogany dining table on upholstered antique chairs next to a tall window that was open on warm days. The transparent white curtains fluttered gracefully in the cool breeze. An enormous floor-to-ceiling mahogany bookcase that extended around three walls of the room surrounded us. It was overflowing with textbooks on pain, literary fiction and biographies. Whenever Cousins explained a complex medical concept to me, he would reach behind him to select a book—usually a text on regional anaesthesia or pain he had co-edited—then show me illustrations and photographs to help me understand it.

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[1] Plutarch, *Plutarch's Lives*, trans. Bernadotte Perrin (Cambridge, MA: Harvard University Press, 1917), 5.

[2] Jacqueline Kent, *The Making of Julia Gillard* (Melbourne: Penguin Books Australia, 2014).

[3] Jacqueline Kent, 'Biography', Life Stories Australia Biography Workshop, 2 December 2022.

[4] Hermione Lee, *Tom Stoppard: A Life* (London: Faber & Faber, 2020).

[5] Hermione Lee, 'A Living Subject', Biographers International Organization Conference, Online, 2020.

Photograph albums occupied the bottom two shelves of the bookcase, and we often studied them. Cousins's face beamed as he described the people in each picture and the stories associated with them. Studying photos triggered his memory, providing me with insights into his family life, leisure activities and his deep affection for those close to him. Framed images of Cousins standing alongside the early pain medicine pioneers lined the bookshelves; he looked proud to be with them. These pictures enabled me to describe his physical appearance, clothes and distinctive glasses at different stages of his career.

Michele usually sat next to her husband during interviews, prompting him when he forgot details and checking dates in one of her dozens of tiny blue diaries. The couple finished each other's sentences and Cousins often deferred to Michele. His face softened and his eyes sparkled whenever they reminisced about their life together.

During the initial research phase, I studied the history of pain medicine in textbooks, journal articles and the archives. Nonetheless, it was invaluable to hear from Cousins, and members of IASP, APS and FPM about the political, cultural and social dynamics that were absent in written accounts. Cousins's autobiographical voice was strong, and he and Michele had a firm view of his place in the history of pain medicine. To prevent their point of view from distorting the biographical portrait, I analysed evidence from a broad range of sources and conducted interviews with a multiplicity of individuals. Whenever I detected embellishments, inventions or contradictions, I questioned them and searched for corroborating evidence.

The science historian Mary Jo Nye suggests a living subject might be tempted to compete with their biographer for control of the story. The subject might contradict the biographer, presenting evidence to support their version of the truth, and they might censor evidence to ensure the biographer portrays their image of themselves.[6] Fortunately, Cousins did not interfere or expect to approve the manuscript. His only request was that I allow him to correct mistakes in scientific and medical information.

A dilemma confronting biographers of living subjects is society's reliance on ephemeral digital communications. Rather than being able to search through letters and diaries stored in archives, contemporary biographers face gaps in the record because of the reliance on email, text messages, social media and myriad other digital forms. I experienced an earlier version of this

[6] Nye, 'Scientific Biography', 242.

issue because Cousins relied on faxes, telegrams, telexes and aerograms to communicate with IASP colleagues and contributors to the textbooks he edited. Unfortunately, only a few copies remain in the archives because, according to IASP's executive officer, 'no-one thought to keep them'.[7]

Another issue faced by biographers of the living is that colleagues and associates alive today might not want their private correspondence with the subject to be made public. And if they agree to be interviewed, they know the subject and others will read their comments, so they might make positive comments to avoid a backlash.[8] Vanity can also impede truth because living witnesses might wish to be seen in the best light, suggests the literary critic, Mark Schorer.[9]

Moreover, an acquaintance might be reticent about revealing aspects of the subject's character or behaviour that reflects badly on them, or they might engage in embellishment, especially about the importance of their relationship with the subject. Hurt feelings and grudges can also reduce the reliability of testimony.[10] This was certainly my experience and one I sought to redress by interviewing a raft of people and re-interviewing some individuals to clarify issues; I re-interviewed, exchanged emails and had telephone conversations with one colleague thirty-three times. I also searched for corroborating evidence in the archives.

Cousins's memories and those of his colleagues provided vital clues about the setting, investigative pathway and reasoning behind their collaborative research studies. Cousins and his colleagues shared their feelings when they experienced breakthroughs, made mistakes and experienced failure. After their seminal study on epidural analgesia, FMC's researchers were ecstatic, as illustrated by the following excerpt:

> 'There was a bit of a race on between different research groups around the world to be the first to publish new methods of spinal pain relief', Cousins recalled forty years later. 'I think it happens every time something new and exciting appears on the horizon.' It was an exhilarating time to be researching epidural pain relief. 'Our team became euphoric', he beamed, adding that, at first, they asked: 'Can it be true?' Then they became convinced it was right. He said part of the reward of research is publishing and communicating the findings. 'It's a signal you've contributed to better

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[7] Louisa Jones, interview by GKD, 7 February 2023.

[8] Lee, 'A Living Subject'.

[9] Mark Schorer, 'The Burdens of Biography', Hopewood Lecture, *The Michigan Quarterly Review* 1 (1962): 251.

[10] Mark Schorer, 'The Burdens of Biography', Hopewood Lecture, 251.

> understanding an illness, and it eggs you on to do more to see if you can improve the way we treat medical conditions.'[11]

Cousins experienced a humiliating defeat in 2011 when his crusade to have chronic pain viewed as a chronic disease foundered, as evident in the following extract:

> When he and Brydon discussed it with senior health department officials they 'hit a brick wall', according to Cousins. It did not help that opinion among pain specialists was divided or that consumer advocates believed defining chronic pain as a disease might increase the stigmatisation of patients. Brydon told Cousins they had no hope of convincing the federal government of the veracity of the concept and that continuing to pursue it with them might alienate key health bureaucrats. 'It's one of the few times in my decade of working with Michael he looked dejected and as if he might give up', Brydon recalled.
>
> Ultimately, Cousins reluctantly conceded, agreeing to terminology that described chronic pain as a chronic condition in its own right, rather than as a disease entity.[12]

I appreciated hearing from Cousins about the political sensitivities of establishing the training body FPM and, after it launched, the views of pain medicine professionals about its impact:

> Cousins contacted the leaders of five specialist medical colleges representing anaesthetists, surgeons, physicians, psychiatrists and rehabilitation specialists to suggest they form a joint advisory committee on pain medicine. 'To my surprise, they all agreed, and we soon started our work', he recalled. 'I wanted to create a joint pain management training program for medical specialists.' It would be a torturous process, however, as he well understood. 'I knew trying to bring several medical specialties together to create a joint training program was a tough ask', he admitted, 'because of professional jealousies, vested interests and historic turf wars'.[13]

Members of the pain medicine community were delighted when FPM launched in 1998. The agreement to run a joint training program, examination and specialist qualification for medical specialists was unique anywhere in the medical world. Neurosurgeon Leigh Atkinson believed setting up FPM was a 'one-in-a-million skill', and it focused people on chronic pain.[14]

I also valued hearing from Cousins's colleagues about their struggle to establish pain centres in Adelaide and Sydney:

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[11] Kelly-Davies, 'Breaking through the Pain Barrier', 170.

[12] Lesley Brydon, interview by GKD, 12 April 2019; Kelly-Davies, 'Breaking through the Pain Barrier', 273–274.

[13] Kelly-Davies, 'Breaking through the Pain Barrier', 239.

[14] Leigh Atkinson, interview by GKD, 1 October 2019.

> Frustratingly for Mather, Austin and McLean, they worked in 'rather bare' laboratories for several months until sufficient funds were available to purchase equipment. To conduct experiments, they borrowed apparatus from other laboratories across the hospital that were equally barren and accessed instruments from the highly popular 'common pool' of analytical tools the hospital provided.[15]

Authorised or Unauthorised?

One of the first choices I faced was whether to write an authorised or unauthorised biography. An 'authorised' biography is one in which the subject 'has read the text and declared the facts revealed therein to be correct', according to Renders, who cautions against writing an authorised biography because it can challenge a biographer's independence and professionalism.[16] Ira Nadel agrees, suggesting an authorised biographer lacks the freedom to ask critical questions and choose how they interpret the evidence, especially when the subject or protective inner circle tries to control the narrative.[17] Carl Rollyson, however, attests that 'authorised' can simply mean 'cooperation', without any expectation by the subject of approving the manuscript. A subject might cooperate by participating in interviews, introducing the biographer to other potential interviewees and providing access to letters, diaries and other vital evidence.[18] This was my experience.

Sydney University's Human Research Ethics Committee required all interviewees to sign a consent form, so it would not have been possible to interview Cousins if he had not agreed to cooperate. He shared letters, contracts and draft speech notes with me and introduced me to twenty-two pain medicine researchers in Australia and around the world, as well as his family and friends, few of whom would have agreed to speak to me without his imprimatur. Nevertheless, as a researcher himself, he respected my right to base the book on what I discovered, and he told me he would not interfere with my interpretation of the evidence.

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[15] Laurence Mather, interview by GKD, 16 April 2019; Kelly-Davies, 'Breaking through the Pain Barrier', 145.

[16] Hans Renders, 'Biography Is Not a Selfie: Authorisation as the Creeping Transition from Autobiography to Biography', in *The Biographical Turn*, ed. Hans Renders, Binne De Haan and Joanne Harmsma (New York: Routledge, 2017), 160.

[17] Carl Rollyson, 'Episode 56: A Talk with Ira Nadel about Philip Roth, Leonard Cohen, and Authorized/Unauthorized Biography' (podcast), *A Life in Biography*, 2 May 2021, https://podcasts.apple.com/au/podcast/episode-56-a-talk-with-ira-nadel-about-philip/id1508239647?i=1000519632636.

[18] Carl Rollyson, 'Scaling the Castle Walls: Dealing with Gatekeepers', interview by Will Swift, 2022 BIO Conference, 14 May 2022.

The decision to write an authorised biography versus one that does not have a subject's agreement or involvement is a vexed issue and one of the central paradoxes of biography. Authorised biographers usually enjoy better access to interviewees and archives than those who are unauthorised; however, a living subject or their gatekeepers might expect a 'quid pro quo' for their cooperation. Examples of interference include trying to control who the biographer interviews and which documents they access. It also involves attempts to influence the biographer's analysis, commentary and conclusions.

Unauthorised biographers avoid these problems, though gatekeepers might block their access to interviewees and evidence. An unauthorised biographer might also be unaware of certain crucial documents or interviewees, much to the relief of the subject's family and friends, who have no intention of sharing this information.

Writing an unauthorised biography sometimes triggers conflict and lengthy legal disputes between the biographer, the subject or their estate. It can also result in a backlash from the public and the media, as occurred for Nigel Hamilton's unauthorised, candid retelling of John F. Kennedy's younger years in *JFK: Reckless Youth.*[19] Hamilton uncovered little-known details about Kennedy's youth, which one reviewer described as 'lurid' and 'inflammatory'.[20] Kitty Kelley also faced intense criticism when *Oprah: A Biography*[21] was published. America's television stations and prominent talk show hosts refused to interview Kelley because they did not want to upset Winfrey and millions of fans boycotted the book.[22]

Avoiding Hagiography

One of my challenges was avoiding hagiography—a biography that treats its subject uncritically, with undue reverence[23]—because of my former doctor/patient relationship with Cousins. Some scholars suggest the critical approach Lytton Strachey applied to his subjects in *Eminent Victorians* marked a move away from the hagiographies of Victorian biographers, and that contemporary life writers tend to adopt a more critical, sceptical approach when

[19] Nigel Hamilton, *JFK: Reckless Youth* (New York: Random House, 1992).

[20] Roger Morris, 'More than a Rake's Progress', *New York Times,* 22 November 1992, https://www.nytimes.com/1992/11/22/books/more-than-a-rakes-progress.html.

[21] Kitty Kelley, *Oprah: A Biography* (New York: Crown Archetype Publishing, 2010).

[22] Kitty Kelley, 'Unauthorized, but Not Untrue: The Real Story of a Biographer in a Celebrity Culture of Public Denials, Media Timidity and Legal Threats', *American Scholar* 80, no. 1 (2011): 32–43.

[23] Nolan, *Biography: An Historiography*, 358.

interpreting evidence about a subject.[24] However, in *Biography: An Historiography*, Melanie Nolan argues that the Victorian era's hagiography has morphed into a more nuanced and inclusive form of the practice that continues today: neo-hagiography.[25] The science historian Vassiliki Smocovitis agrees, especially when writing about a living subject.

Smocovitis suggests that a complex relationship develops between a biographer and living subject through years of interviews and interaction. She admits this occurred for her while writing the biography of the evolutionary biologist Ledyard Stebbins.[26] During those thirteen years, Smocovitis noticed her life converging with Stebbins's, particularly their values, concerns and attitudes.[27] Nadel acknowledged this as one of his challenges while writing biographies of Tom Stoppard[28] and David Mamet.[29] So did Mark McKenna, who wrote a biography of the Australian historian and public intellectual Manning Clark.[30]

During the seven years it took to research and write *An Eye for Eternity*, McKenna formed a close relationship with the late Manning Clark through his letters and diaries. He also drew close to Clark's family members and friends, and he became embedded in their networks. This concerned him because he knew he risked writing a hagiography. 'To come close to Clark, to know him intimately, and at the same time keep my distance was always a struggle', McKenna admitted in the book's preface, adding:

> This is the biographer's dilemma: to resolve the tension between closeness and distance, to separate the voice of the biographer from the voice of the subject, to know and reveal the subject without becoming the subject. If I was to write Clark's biography, I had to wrest control of his life from his own voice. If I was to do more than simply relay his telling of his life—a story that he [Clark] never tired of telling, I had to come as close to him as possible yet remain far enough apart.[31]

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[24] Ira B. Nadel, *Biography: Fiction, Fact and Form* (London: Macmillan Press, 1986), 6.

[25] Nolan, *Biography: An Historiography*, 358.

[26] Vassiliki Betty Smocovitis, *Botany and the Evolutionary Synthesis: The Life and Work of G. Ledyard Stebbins, Jr* (New York: Cornell University, 1988).

[27] Vassiliki Betty Smocovitis, 'Pas de Deux: The Biographer and the Living Biographical Subject', in *History and Poetics of Scientific Biography*, edited by Thomas Söderqvist (London: Routledge, 2007).

[28] Ira Bruce Nadel, *Double Act: A Life of Tom Stoppard* (North Yorkshire: Methuen Drama, 2004).

[29] Ira Nadel, *David Mamet: A Life in the Theatre* (New York: Palgrave Macmillan, 2008).

[30] Mark McKenna, *An Eye for Eternity: The Life of Manning Clark* (Melbourne: Melbourne University. Publishing, 2020).

[31] McKenna, *An Eye for Eternity*, ix.

In an interview with me for my podcast *Biographers in Conversation*, McKenna admitted one of his biggest struggles was 'to remember at all times that I was telling the story, not Manning. That it was my biography of his life, and I was the storyteller.'[32]

This, too, was one of my dilemmas. For the first few months of interviews with Cousins, I wrestled with the demands of loyalty I felt to my subject. I knew my task was one articulated by Australia's doyenne of biography, Brenda Niall. Niall noted that biography is 'an act of imaginative and creative sympathy rather than romantic identification or possession'.[33] Committed to writing a deeply researched, independent biography, I resolved to interpret my subject's character and behaviour on the weight of evidence rather than from my subjective perspective.

While acknowledging that true objectivity is impossible to achieve because each biographer's interpretation is influenced subliminally by their background, point of view and prejudices, I felt a deep responsibility to represent the truth of my subject for the historical record and my readers. My task was to view Cousins dispassionately and portray him truthfully, replete with the frailties common to all human beings. This involved 'not stepping around, avoiding, whitewashing, downplaying or keeping silent about my subject's prejudices or "personal foibles"'.[34]

My predominant experience of Cousins was as a compassionate clinician determined to reduce the impact of chronic migraine in my life. Initially, I found it challenging to detach from the close relationship we had built over several years and to maintain a critical distance. It was also difficult to adopt an attitude of scepticism during interviews because of years of implicitly trusting him as my doctor. Nevertheless, I gradually disengaged from our earlier relationship and adopted an impartial attitude. I realised this was occurring when, after a few months of interviews, I started noticing and questioning contradictions, ambiguities and inconsistencies.

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[32] Mark McKenna, interview by GKD, (podcast) *Biographers in Conversation*, 6 June 2024, https://www.biographersinconversation.com/s01e10-mark-mckenna-an-eye-for-eternity/.

[33] Michael McGirr, 'Noble Work for Nobel Cause: Four Pioneering Australian Women Writers', *Sydney Morning Herald*, 1 May 2020.

[34] Hermione Lee, 'A Biographer's Choices', Biography Lab Plenary, Biographers International Organization, 21 January 2023.

With so many sources of error, bias and distortion obstructing the path to certainty, how can a biographer assure readers they are representing the truth of a subject, or at least a plausible version of the truth? Holmes advises writers to ask:

> Does my version hold good for readers? Can they believe I have tried to tell the truth? Can they feel they've met this person? And can they see why I think this life is still important, why it's still significant to us?[35]

I used these questions as a litmus test to challenge myself to ensure I represented an authentic version of the truth based on the weight of verified facts and evidence from a vast range of sources rather than crafting a hagiography.

Privacy and Secrecy

Biographers have a responsibility to protect the privacy, dignity and security of a living subject and their family. I questioned, however, whether I should reveal secrets if I discovered them? The biographer Diane Middlebrook explored the principle of informed consent in biography and whether a biographer is ethically obliged to respect a subject's wishes about disclosure. Middlebrook also asked if the principle of doctor/patient confidentiality extends to biography and whether some information is 'off limits' for ethical reasons. She concluded by cautioning biographers against disclosing secrets that could shame or hurt a subject or their family.[36] So did Renders, who advised 'fair play and reasonableness'.[37]

Kati Marton, who wrote the biography of former German chancellor Angela Merkel,[38] said she feels compassion for people in the public eye, especially those who are trying to 'do good things'. Marton advises biographers to treat their subjects with humanity first and foremost, rather than 'Aha, what can I find here? What trivial detail … what embarrassing detail will I be able to uncover?'[39] Middlebrook agrees, urging caution to avoid inflicting harm.[40] Renders

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[35] Wittmann, 'The Art of Biography No. 7 Richard Holmes', 143.

[36] Diane Middlebrook, 'Telling Secrets', in *The Seductions of Biography*, ed. David Suchoff and Mary Rhiel (New York: Routledge, 2016), 124.

[37] Hans Renders, 'Unique Lives and Current Biography: An Interview with Hans Renders', interview by Heinrich Matthee, *Lit Net*, 25 May 2021.

[38] Kati Marton, *The Chancellor: The Remarkable Odyssey of Angela Merkel* (New York: Simon and Schuster, 2021).

[39] Kati Marton, 'Scaling the Castle Walls: Dealing with Gatekeepers', interview by Will Swift, 2022 BIO Conference, 14 May 2022.

[40] Middlebrook, 'Telling Secrets', 127.

counsels biographers to take a benevolent attitude towards a living subject, acknowledging that, in practice, each writer's method of handling sensitive information is determined by their own morality.[41]

Nevertheless, is a biographer allowed to reveal something that might tarnish the reputation of a dead subject? Renders suggests biographers experience a social pressure to bestow posthumous praise to the newly dead. If so, how long should it last? He considers this is one of a biographer's most difficult ethical decisions.[42]

The French Enlightenment writer and philosopher Voltaire once wrote to a friend: 'We owe respect to the living; to the dead, we owe only the truth.'[43] Claire Tomalin reflected on this remark before embarking on *The Invisible Woman*,[44] the biography of Nelly Ternan, Charles Dickens's secret lover of twelve years. Although Dickens had been dead for over a century, Tomalin sensed it would dismay his readers to learn of his clandestine affair because it cast a new light on him and his character, one that conflicted with his carefully curated reputation as an upstanding family man and pillar of society.[45]

Hamilton claims that curiosity about real individuals drives contemporary biographers and readers.[46] Lee suggests readers long to learn about a subject's 'motives and fears, sexual habits and dealings with money'. Other curiosities are a subject's 'behaviour as a partner or parent, illnesses, peculiarities, even dreams and fantasies'.[47] In deciding what to include, Hamilton counsels biographers to ask themselves what the reader 'wants to know and what they really need to know'.[48]

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[41] Hans Renders, 'History That Addresses Biography: Ethics and the Vatican', in *Fear of Theory*, ed. Hans Renders and David Veltman (The Netherlands: Brill, 2021), 115.

[42] Renders, 'History That Addresses Biography', 120.

[43] Iskra Fileva, 'What Do We Owe the Dead?' *New York Times*, 27 January 2020, https://www.nytimes.com/2020/01/27/opinion/kobe-bryant-death-tweets.html.

[44] Claire Tomalin, *The Invisible Woman: The Story of Nelly Ternan and Charles Dickens* (London: Penguin, 1991).

[45] Tomalin, *The Invisible Woman*, 4.

[46] Nigel Hamilton, 'The Missing Key: Theorizing Modern Historical Biography', in *Fear of Theory*, ed. Hans Renders and David Veltman (The Netherlands: Brill, 2021), 32–34.

[47] Lee, *Biography: A Very Short Introduction*, 8.

[48] Nigel Hamilton, *How to do Biography. A Primer* (Boston: Harvard University Press, 2008), 112.

In ‘Breaking through the Pain Barrier’, I explored each of the topics Lee mentioned, though, apart from a couple of subtle hints, I excluded mention of Cousins’s sexual habits, believing he had a right to protect this aspect of his life from prying eyes. Apart from privacy concerns and the risk of embarrassing him and his family, his sexual habits were not central to his story.

My task was to balance readers’ insatiable curiosity with respecting Cousins’s privacy and dignity. To me, this meant being truthful and examining my conscience whenever I had to decide whether to include sensitive material and secrets.

Ethics in Biography

One issue for modern biographers is the lack of rules or a code of ethics in a rapidly changing media and publishing landscape. Unable to find an accepted system of norms, values or morals, I found myself regularly reflecting on the ethics of disclosure, especially for a living subject. Lee suggests ten possible rules for biographers, including telling the truth, citing sources and not inventing, though she notes that these rules are unstable and that biographers often break them.[49]

While biographers lack a formal code of ethics, the sociologist Jerome Manis believes they accept certain implicit moral obligations, such as the search for truth through rigorous research. Manis suggests that the starting point for a statement of ethics includes painstaking documentation, citing sources and fact-checking. He also advises biographers to interpret the evidence with sensitivity and to question rumours and gossip.[50]

Based on these suggestions, I crafted a statement of ethics before drafting the manuscript. After pinning it onto the noticeboard above my desk, I often reflected on it, especially when confronting decisions about the disclosure of sensitive material or secrets. It included:

- maintaining a critical distance from my subject and interviewees
- prioritising evidence from primary sources
- scholarly research from a multiplicity of sources
- corroborating evidence

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[49] Lee, *Biography: A Very Short Introduction*, 8–18.

[50] Jerome G. Manis, ‘What Should Biographers Tell?: The Ethics of Telling Lives’, *Biography* 17, no. 4 (1994): 387.

- pursuing the truth based on corroborated facts
- analysing evidence and basing interpretation on the weight of evidence rather than my subjective perspective
- questioning contradictions, inconsistencies and ambiguities
- critically examining discord, disputes, gossip, rumours and innuendo
- citing sources accurately
- applying empathy and humility
- honouring the privacy and dignity of my subject and his family
- avoiding hagiography.

Memory

The fallibility of human memory and unreliable narrators are sources of distortion in biography. The historian Alistair Thomson suggests that people craft memories that give them a sense of comfort with their lives. This can involve remaking or repressing traumatic and painful memories that reflect unresolved issues.[51] We quickly forget the details of an experience, Thomson explains, and every time we 'revisit or *re-remember*', we create a new version of the event to make sense of it. This is one reason historians are wary of memory as a source of truth, because physical deterioration and nostalgia can distort it.[52]

To trigger Cousins's memory, we studied photographs together, starting with faded black and white images from his childhood and progressing through dozens of family albums. Memories flooded back as he recounted the stories relating to each photograph. Nevertheless, the unreliability of memory concerned me deeply because of his advanced age and, later, Parkinson's disease. Several of the people I interviewed were also elderly—one surgeon was ninety-nine—adding to my sense of unease. Many of the events depicted in the biography occurred over forty years ago, so fading and reconstructed memories risked distorting the evidence. So did the nostalgia of elderly colleagues, although when I examined their views about Cousins from letters they wrote during the 1970s, their remarks today were consistent with those expressed in the letters.

[51] Alistair Thomson, 'Anzac Memories: Putting Popular Memory Theory into Practice', in *The Oral History Reader,* eds, Robert Perks and Alistair Thomson (New York: Routledge, 2002), 344.

[52] Alistair Thomson, 'Life Stories and Historical Analysis', in *Research Methods for History*, ed. Simon Gunn and Lucy Faire (Edinburgh: Edinburgh University Press, 2016), 106.

To address the issue of unreliable narrators, I validated each interviewee's memories against those of other interviewees, archival records and the pain medicine literature. I also compared Cousins's recollections during our conversations with those he expressed in oral history interviews from late 1997 and 2014, though these memories were expressed from his point of view and his well-rehearsed narrative of his life, so I examined them cautiously. Whenever I could not verify evidence or unravel contradictions, I admitted it to the reader.

During the interviewing, drafting and editing stages, Cousins retained a sharp memory, and he reviewed all scientific and medical information for accuracy. So did three pain medicine scholars in Australia and overseas. Fortunately, Michele had kept tiny diaries documenting decades of the family's activities, enabling me to verify dates, places and events.

In conclusion, my key learning from this chapter is that writing about a living subject provides biographers with a wealth of opportunities to capture their essence and produce a deeply nuanced account of their life. These advantages can only be realised, however, when a writer avoids the perils of the close relationship they develop with a subject after interacting with them for many years. This topic is further explored in the next chapter, which examines the narrative choices I made to craft an engaging story based on a search for the truth of my subject.

Chapter Four: Narrative Strategy

Settling on the narrative strategy for *Breaking through the Pain Barrier* and later, 'Breaking through the Pain Barrier', the rewritten version of the biography, involved nearly six years of experimentation with a variety of narrative devices. This chapter examines the decisions I made while crafting the published version of the biography and how the narrative strategy evolved while rewriting it as a thesis. Five broad categories of choice are explored: authorial voice, employing novelistic devices, structure, interpretation and my visibility within the story.

Authorial Voice

One of my goals was for readers to *feel* Michael Cousins's passion for pain medicine and his patients and his emotional responses when his efforts were thwarted. To my horror, however, members of my writing group who reviewed an early draft said all they could feel was boredom because it read like an encyclopedia, and, worse still, a resume!

Clearly, I had allowed Cousins's autobiographical voice and point of view to dominate, and I was serving as his ventriloquist, perpetuating his private myths and preferred image and writing the biography in his words. I realised he was accustomed to expressing his point of view—often forcefully—in journal articles, speeches and media interviews, and he had participated in several oral history projects. This was a significant learning for me and a major turning point in my journey as a first-time biographer.

Members of my writing group advised me to strengthen my authorial voice. Although I had a vague understanding of this elusive concept, I could not grasp its essence in a practical sense, so I studied the academic literature.

After studying the views of scholars such as Hermione Lee, Hans Renders and Richard Holmes, to name a few, I finally grasped authorial voice as a theoretical concept. However, I was still unsure how to strengthen mine. Hamilton advises biographers to follow their instincts. 'Your voice will emerge as you write', he remarked, adding:

> Start with the subject matter and your narrative design, and let your voice find itself. Biography is storytelling. And to tell your story well, in your own way, stamped with

> your own individuality, you need to be willing to work hard and to experiment, accepting that biography is a process of trial and error and of iteration.[1]

During 2019, when I shared my authorial voice concerns with a friend, she suggested I imagine us sitting on the sofa in front of a roaring fire sipping a glass of wine. 'Please tell me about Michael Cousins', she said. The next day, imagining my friend was with me, I told her the story, recording it on my iPhone. When I listened to it, I could hear my natural voice emerging rather than Cousins's autobiographical voice and academic language. During the following months, I dictated every paragraph into the iPhone, reflected on it, then edited the text. Finally, my authorial voice emerged.

Nonetheless, I knew that a subject's remarks were important for illuminating their character. I was eager for Cousins's voice to be present without it detracting from my voice as the narrating author, so I wove the most revealing of his comments into the narrative as direct and indirect quotes from our interviews, journal articles, speeches and media commentary because they reveal his deep commitment to advancing pain medicine. The quotations and remarks I paraphrased also demonstrated his communication skills, conviction and willingness to challenge accepted norms within the medical profession. The following excerpt is from an oration he presented in 1997 at the American Society of Anaesthesiologists conference in San Diego:

In this address, he decided to 'go out on a limb', introducing two new concepts—pain relief as a universal human right and chronic pain as a disease in its own right:

> Chronic pain is the silent epidemic. Patients with chronic pain often suffer silently. Relatives and others are silent; they hope it won't happen to them. Society is silent; mostly, it's unaware of the enormous human and financial cost. Politicians are silent because the costs are overwhelming. A huge gap exists between knowledge and practice, and this gap is widening as knowledge increases exponentially.
>
> Cousins concluded the first part of his lecture by declaring: 'The plight of patients with chronic pain points to the need for a unique approach, one viewing pain relief as a basic human right. Everyone has a right to access pain management services.'
>
> Asserting that it was up to pain professionals to take this concept to the community at large, he warned his audience it would be a 'tough call' to change medical and societal attitudes. To some audience members, equating access to pain management with freedom from slavery or torture was provocative; his claim raised their hackles.

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[1] Hamilton, *How to do Biography*, 124–25.

> A few anaesthetists urged him to 'tone down his comments' because they believed he was giving pain and its management too much prominence. 'They didn't want it to be so visible', he recalled. His enormous self-belief, however, gave him the courage to take a moral stand despite this resistance. Refusing to be silenced, he urged his colleagues to take the lead in the larger debate that access to pain management was a fundamental human right. 'We would want nothing less for ourselves and certainly for our loved ones.'[2]

In 2022, when I re-read the published version of Cousins's biography, I noticed my voice as the narrating author was tentative and lacked authority. Once again, I studied the academic literature to find clues on how to strengthen my voice. A 2023 literature review of research on authorial voice enabled me to grasp critical elements of this concept, which some researchers suggested was a 'multifaceted metaphor' and 'mythical beast' reflecting an author's worldview, stance and opinions. Several researchers portrayed authorial voice as encompassing the writer's character, identity and presence in the narrative, and many viewed it as an expression of agency and self-representation. Others suggested it is how a reader senses the author behind the writing.[3]

The writer and Oxford University tutor Rebecca Abrams notes that all authors need a voice through which to narrate, and the voice they employ should be consciously constructed so it is appropriate for the themes and ideas explored in a story: 'As writers, we are reaching out to our readers through the text. We're asking them to trust we are authentic and that we have authority to author the story we are telling them.'[4]

In trying to identify their voice, Kate Kennedy suggests authors step back and listen to their 'alive human voice', asking questions such as 'How do I talk?', 'How do I write?', 'What do I find amusing?', 'Do I have a deep sense of irony?', 'Do I poke fun at my characters in a respectful, but nonetheless, kind of humorous way?'[5]

Once archives and Australia's international borders reopened and I completed additional archival research, I incorporated new evidence into the original manuscript and rewrote the biography. By that stage, I had worked on the project for five years and felt more confident. I

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[2] Cousins, 'Pain: The Past, Present and Future of Anesthesiology?' 551; Kelly-Davies, 'Breaking through the Pain Barrier', 236–237.

[3] Olga Mhilli, 'Authorial Voice in Writing: A Literature Review', *Social Sciences & Humanities Open* 8, no. 1 (2023): 1–11.

[4] Rebecca Abrams, 'Authorial Voice', Oxford Writing Mentors, Workshop Notes, 28 May 2024.

[5] Kennedy, interview.

noticed my authorial voice was stronger and more authoritative, perhaps because I had gained a deeper understanding of my subject through exhaustive research, analysis and reflection. My journey from a novice unable to grasp the concept of authorial voice to an established writer with a confident voice was a rich learning experience.

Writing Like a Novelist

Holmes encourages biographers to write creatively to enable readers to imagine the subject vividly, empathise with them and feel part of the action. An aspect of imaginatively reconstructing a life is recreating scenes based on corroborated facts from a range of sources.[6] 'If you want to tell a story', the political biographer, Robert Caro, advises, 'you have to make the reader see the scene in which it's taking place. Unless you're doing that, how do you make the reader understand what's really going on?'[7]

To help him revive scenes from Lyndon Johnson's life, Caro immersed himself in places that shaped the former president, including the arid, rocky landscape of the Texas Hill Country where Johnson's forebears had prospered as farmers—though they later experienced financial ruin because of extended droughts, soil erosion, failed crops and crippling interest rates. Johnson's father initially succeeded and was a pillar of the community, but his hubris and reckless over-investment in his late father's farm plunged his family into bankruptcy. From then on, Texas Hill Country locals scorned the family, who became a laughing stock. Caro insists this descent into poverty and ridicule profoundly shaped Johnson.[8] By living in the Texas Hill Country for three years and conducting forensic research, Caro was able to suggest with a high degree of certainty how Johnson's character, behaviour, motivations and decisions were influenced by his family's history.[9]

As described in the introductory chapter, I retraced Cousins's footsteps to absorb the significance of transformative places in his life. To provide the sensory details to recreate scenes I often asked him and other interviewees: 'What did you *see*?', 'What did you *smell*?', 'What did you *hear*?', 'Who else was there?', 'What did you *do*?' and 'How did it make you

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[6] Wittmann, 'The Art of Biography No. 7 Richard Holmes', 145–46.

[7] Robert Caro, 'Robert Caro on Robert Caro: In Conversation with Kai Bird', Graduate Centre New York, 15 October 2019, https://www.youtube.com/watch?v=tz2L16b51AE&t=20s.

[8] Robert Caro, *The Years of Lyndon Johnson. Volume 1, The Path to Power* (New York: Alfred A. Knopf, 1982), 3–139.

[9] Caro, 'Robert Caro on Robert Caro'.

feel?' These insights, combined with photographs, journal articles and historical documents, enabled me to reconstruct scenes filled with vivid sensory details and Cousins's emotional response to each situation. The following scene shows him as an idealistic young anaesthesia registrar searching for a seminal textbook on pain:

> At the 'crack of dawn' the following Saturday, Cousins jolted awake, even though his last shift for the week had ended only a few hours earlier. After a breakfast of wheatgerm and black strap molasses— 'terrible stuff' Forbes Carlile claimed increased athletic performance—Cousins drove to Sydney University's Medical School, a Gothic sandstone building with stained glass windows. Checking his watch every few minutes, he stood outside the library's highly varnished, dark wooden doors.
>
> On the dot of nine o'clock, a small woman with bobbed grey hair and round glasses opened the doors. Cousins smelled the familiar musty odour that brought back memories of spending long hours studying in the library. He headed straight to the catalogue; a series of wooden drawers filled with white index cards then looked up 'B'.
>
> 'Yes! He's here', Cousins remembers gasping, barely able to contain his excitement.
>
> He had found Professor John J. Bonica's magnum opus from 1953, *The Management of Pain*,[10] the only book that discussed everything known about pain and its treatment. Cousins made a beeline for the shelf that held the key to his future, hurriedly scanning the call numbers. He recalled his heart pounding as he glimpsed the bulky tome. After pulling it from the shelf, he carried it to a vacant desk.
>
> At the same time as he pulled out a chair, he opened the book and tried to read it. After checking the index, he opened to the right section, then ran his finger down each page, line by line.[11]

To access the information I required to craft this scene, I visited Sydney University's medical school library with Cousins. His memories rushed back so intensely he said he felt as if he was still a medical student studying for exams. Later, I returned on my own, absorbing its sights, sounds and smells. The medical school's archivist, who is also RNSH's archivist, escorted me around old sections of buildings so I could sense how they appeared to Cousins in the 1960s. We also spent many hours discussing the history and politics of both institutions.

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[10] John J. Bonica, *The Management of Pain* (Philadelphia: Lea & Febiger, 1953).

[11] Kelly-Davies, 'Breaking through the Pain Barrier', 101–102.

The Centenary Book of the Sydney University Medical Society and *150 Years of the Faculty of Medicine*[12] contained invaluable historic information, as did the online museum and archive of the university's medical school.[13] The online museum includes photographs of the buildings, staff and alumni, historical documents and profiles of staff and students. Finding Cousins's 1963 *Senior Year Book* in the online museum was exciting because it described his character and behaviour as a medical undergraduate. He also kept a copy of the year book in his private collection. It included a photograph of him during his final year of medical school, enabling me to describe his physical features accurately.[14]

Supplementing this evidence with Cousins's interview recordings and transcripts enabled me to reproduce his descriptions precisely, using his vocabulary and including his emotional responses.

Caro insists that facts are the key to his authentic character studies, and that these result from accumulating a trove of detailed information about people. 'There is no one truth', he said, 'but there are an awful lot of objective facts. The more facts you get, the more facts you collect, the closer you come to whatever truth there is.' Caro gathers evidence through hundreds of interviews, among other sources, admitting he has re-interviewed some people dozens of times, even though it sometimes annoys them.[15]

I mirrored Caro's approach by interviewing nearly one hundred individuals, many of them multiple times, to query new evidence and clarify contradictions and ambiguities. When Cousins's colleagues became frustrated with follow-up emails and questions, I explained the crucial importance of substantiating all evidence before I included it in the biography. Otherwise, I risked breaking my contract with readers to create an authentic account of my subject's life. Most accepted this rationalisation, however, one detractor refused to respond to

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[12] Sefton, Cheng and Thong, *The Centenary Book of the Sydney University Medical Society*; Ann Jervie Sefton, Yvonne E. Cossart and Louise Freckelton, *150 Years of the Faculty of Medicine* (Sydney: Sydney University Press, 2006).

[13] Sydney Medical School Online Museum and Archive, accessed 3 February 2020, https://www.sydney.edu.au/medicine/museum/mwmuseum/index.php/Sydney_Medical_School_Online_Museum_and_Archive.

[14] 'Michael John Cousins', in *Senior Year Book: University of Sydney Faculty of Medicine*, edited by Margaret Blaket (Sydney: Sydney University Press, 1963). MJC Private Collection and Sydney Medical School Online Museum, accessed 3 February 2020, https://www.sydney.edu.au/medicine/museum/mwmuseum/index.php/Senior_Year_Books

[15] James Santel, 'The Art of Biography No. 5 Robert Caro', *Paris Review*, no. 216 (Spring 2016): 149.

further questions after a long interview and four rounds of emails, each of which raised more puzzling questions I was eager to resolve.

Manipulating the pace and rhythm is another narrative device biographers use for dramatic effect. Hamilton and Renders advise authors to develop the narrative pace from the opening scene. Establishing pace in the first forty pages of a biography captures the reader's attention and establishes the writer's authority in recounting the story, the two scholars counsel.[16] In *The Path to Power: The Years of Lyndon Johnson*,[17] Caro employed rhythm to enable readers to feel Johnson's desperation to be elected to Congress and accumulate wealth: 'I tried to infuse the descriptions of his campaigning with a rhythm of desperation', Caro said. 'I had a note card attached to the lamp on my desk. I sometimes put a card on there as a reminder to myself. This one said: "Is there desperation on this page?"'[18]

In the prologue to 'Breaking through the Pain Barrier', I recreated a scene from Cousins's description of treating two critically burned boys. The setting is a Saturday evening in 1964 in a hospital driveway. Cousins was waiting for the boys to arrive in an ambulance:

> Later that night, a tall, athletic young man with glossy dark hair stands in front of St George Hospital's Casualty Department. His eyes are fixed on the entrance to the hospital's driveway. That young man is Dr Michael J. Cousins.
>
> He finished medical school twelve months earlier and is now a resident medical officer at St George Hospital in southern Sydney. At this stage of his career, he does not know which medical speciality to pursue and often worries he might never find an area of medicine that is right for him.
>
> Suddenly, he hears heart-wrenching screams from the end of the driveway. Swivelling his head towards the sound, he notices two tiny, blackened figures limping up the path.
>
> He sprints towards the children, the edges of his white coat flapping in the wind, his stethoscope swinging around his neck. As he gets closer, he realises they are the two burned boys he was waiting for in the ambulance bay. He notes the skin on the boys' faces is black and the skin on their heads, torso, arms and legs looks completely burned off. The boys wail, and their blackened hair stands on end, making it look fuzzy.

[16] Hamilton and Renders, *The ABC of Modern Biography*, 29.

[17] Caro, *The Years of Lyndon Johnson*.

[18] Santel, 'The Art of Biography No. 5 Robert Caro', 143.

> Once the boys are inside, Cousins gently inserts needles into the backs of their burned hands. The needles are attached to drips. Their hands balloon and he is glad he got the cannulas in on time—any later and the swelling would have prevented it. First, he runs tiny doses of morphine through the drips, then places oxygen masks over the boys' scorched faces. The morphine, however, does not work. The children's piercing screams reverberate through the Casualty Department.
>
> For the next forty-eight hours, Cousins and the hospital's medical and nursing team keep a vigil by the boys' bedsides. Thankfully, the children survive; however, the staff fail to ease their horrific pain.
>
> Haunted by the boys' suffering, Cousins resolves to learn more about pain and its treatment.[19]

A sense of urgency and panic are conveyed in this scene by narrating it in a moment-by-moment manner, using short sharp sentences that create a staccato rhythm. It is written in present tense to increase immediacy and heighten the drama. The reconstruction shows Cousins in action, conveys his thoughts and provides clues about his character, especially his empathy. My goal was to enable readers to feel as if they were in the casualty department with Cousins, *seeing* him in their 'mind's eye' and *feeling* his compassion for his patients.

After drafting this scene, I wrestled with whether I should include it because I could not corroborate Cousins's recollections. Memories fade quickly after an event and discrepancies occur between the accounts of different witnesses. Moreover, members of my writing group said early drafts sounded too much like Cousins's point of view as a doctor-hero. Once again, I had allowed his autobiographical voice to dominate, as described earlier. I realised that as he told and retold this story multiple times in media interviews and oral histories, he perceived it as the true version of events. My task was to view it with scepticism until I could verify it.

In the published version of the biography, the prologue opens with a scene in the children's backyard as they enjoy a bonfire and firecrackers. Suddenly, a gust of wind blows flames from the bonfire towards the boys, burning them. I reconstructed this scene from the version of events the boys' parents told Cousins and the nurses. After exhaustive attempts, I could not locate the burned boys, or their parents, and hospital records were inaccessible because of strict privacy rules. Although a nurse who worked alongside Cousins in the casualty department confirmed the story, it was still second-hand information that could not be corroborated.

[19] Kelly-Davies, 'Breaking through the Pain Barrier', 95-96.

During my residency at Oxford's Centre for Life Writing in 2023, Hermione Lee led a workshop that explored the boundaries between fact and fiction. When I told her about my inability to verify the story of the bonfire, she asked me how important the scene was to the prologue. My classmates joined in the conversation, expressing varying views about this question. At one point, Lee asked us to consider the limits of plausibility, which provoked more debate. Towards the end of the discussion, she suggested evidence should only be included if it is corroborated by two or more witnesses.[20] This advice convinced me to delete the scene in the rewritten version of the biography. It was a significant learning experience about the ethical choices biographers face when they imaginatively reconstruct a life. It also taught me about the power of restraint and the need to give readers the space to imagine a situation for themselves.

One of a biographer's decisions is how to get as close to the truth as possible. While gaps in the historical record call for biographers to use their imagination to recreate a life, Nadel warns them to avoid carrying the fiction too far to the point they disregard the truth.[21] Still, Brian Matthews, who wrote the biography of Louisa Lawson, the nineteenth-century publisher, women's rights advocate and mother of the Australian poet Henry Lawson, admits the temptation to invent and embroider is powerful whenever the historical record contains fragmentary evidence.[22]

Edgar Johnson was admired for his 'towering and exhaustive scholarship'.[23] Yet he admitted that what he included in his biographies of Charles Dickens[24] and Sir Walter Scott[25] depended on what facts were 'discoverable' because vital evidence had been lost, damaged or destroyed since the nineteenth century.[26] Claire Tomalin faced a similar issue while writing *The Invisible Woman.* Seven years before his death, Dickens destroyed all letters written to him over his lifetime, though he could not convince the recipients of his letters to do the same. After his

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[20] Hermione Lee, 'Making Things up', Laura Marcus Life-Writing Workshop, Centre for Life Writing, Oxford University, 2 June 2023.

[21] Nadel, *Biography: Fiction, Fact and Form*, 4.

[22] Brian Ernest Matthews, *Louisa* (Brisbane: University of Queensland Press, 1998), 6–7.

[23] Ronald Sullivan, 'Edgar Johnson, 93, Biographer of Dickens and Scott, Is Dead', *New York Times*, 29 April 1995, https://www.nytimes.com/1995/04/29/obituaries/edgar-johnson-93-biographer-of-dickens-and-scott-is-dead.html.

[24] Edgar Johnson, *Charles Dickens: His Tragedy and Triumph* (New York: Simon and Shuster, 1952).

[25] Edgar Johnson, *Sir Walter Scott: The Great Unknown*, vol. 1 (Toronto: Ardent Media, 1970).

[26] Edgar Johnson, 'The Art of Biography: An Interview with Edgar Johnson', *Dickens Studies Annual* 8 (1980): 1.

death, Dickens's children destroyed evidence of their father's clandestine affair and, in the opening chapter of *The Invisible Woman*, titled 'N', Tomalin wrote:

> This is the story of someone who—almost—wasn't there: who vanished into thin air. Her name, dates, family and experiences very nearly disappeared from the record for good. Why and how this happened is the theme; and how—by a hair's breadth—she was reclaimed from oblivion despite strenuous efforts to keep her there.[27]

Despite gaps, evidence found in historical documents is essential for recreating past lives. Archival sources, though, must be viewed with scepticism because they contain biases resulting from a raft of factors, including who created the document, who decided to keep it, how much of the record they kept and their reasons for keeping it. Mark McKenna faced this dilemma while writing Manning Clark's biography. Throughout his life, Clark painstakingly curated his archive of letters and diary entries for biographers, leaving them detailed notes and instructions. One of McKenna's tasks was to resolve why his subject included, emphasised and suppressed certain evidence, the intention of Clark's notes to biographers, and what these questions indicated about Clark's character and behaviour.[28]

One reason historical records are fragmentary is highlighted in the prologue to Tomalin's biography of the seventeenth-century diarist Samuel Pepys. During an argument with his wife Elizabeth, and in a rage, Pepys tore many of his private papers into small pieces, including his love letters to her. He also shredded his will, in which he had left all his property to Elizabeth. 'Yet all the time a corner of himself was calm enough to notice and set aside certain papers', Tomalin wrote. These documents included the couple's marriage licence because: 'The law must be respected.' Afterwards, Pepys threw all the ripped papers into the fire, except for sections of the will and the first letter he wrote to Elizabeth.[29]

Structure

Contemporary biographers enjoy considerable freedom in how they construct the plot of a life story, which is driven by the subject's character. The plot is a pattern of action that determines how scenes, events, descriptions and dialogue are organised into a cohesive narrative. The structure of a narrative refers to the active connections between units and how the action is

[27] Tomalin, *The Invisible Woman,* 3.

[28] McKenna, *An Eye for Eternity*, ix.

[29] Claire Tomalin, *Samuel Pepys: The Unequalled Self* (London: Vintage, 2007), xxxiv.

sequenced. In biography, the plot is predetermined and the biographer guides readers through the subject's journey by revealing their character and its development during the course of their life. If a subject's innate character traits, such as audacity, tenacity and resilience, led to their success, then this is an example of their character driving the plot. Through reconstructed scenes, the biographer shows these characteristics in action, propelling the reader forward.[30]

Biographers can proceed forwards or backwards or structure the narrative around themes rather than chronology. Instead of telling a life in full, some biographies represent 'slices of life' by focusing on transformative moments and turning points.[31] This is the approach I chose because it enabled me to focus on pivotal moments in Cousins's life and the impacts of crucial decisions on his trajectory.

A critical choice for every writer is how to open the narrative. Hamilton maintains that the role of a biography's introductory passages is to intrigue the reader.[32] Novelist David Lodge concurs, suggesting that the opening should raise questions in the reader's mind and delay the answers.[33] One option is to start at the end of the subject's life. T. S. Eliot referred to this approach in the poem *Little Gidding*: 'What we call the beginning is often the end. And to make an end is to make a beginning. The end is where we start from.'[34] This was the approach Alexander Masters adopted in *Stuart: A Life Backwards*, the biography of his friend Stuart Clive Shorter.[35] The story starts with Stuart Shorter as an adult and works backwards, examining his troubled childhood and how it contributed to homelessness and criminality in later years.

In contrast, Lee opted for a unique way of commencing *Virginia Woolf*.[36] She wrestled with how to open Woolf's biography, wondering whether to begin by stating Woolf's birth date and the names of her parents. Or should she give the date and cause of Woolf's death? Other options Lee considered were describing Woolf's family history to enable the reader to familiarise

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[30] Kate Kennedy, 'Character, Plot and Structure', Workshop Notes, Oxford Writing Mentors, 29 May 2024.

[31] Ted Widmer and Benjamin Moser, 'Slice of Life or Cradle to Grave?', Biographers International Organization Annual Conference, Online, May 2022.

[32] Hamilton, *How to do Biography*, 130.

[33] David Lodge, *The Art of Fiction* (London: Random House, 2012), 14.

[34] T. S. Eliot, *Little Gidding* (London: Faber and Faber, 1942).

[35] Alexander Masters, *Stuart: A Life Backwards* (New York: Delacorte Press, 2006).

[36] Hermione Lee, *Virginia Woolf* (London: Vintage, 1977).

themselves with the context of the author's ancestry, country and class, or to position Woolf as a member of the social and intellectual group she inhabited. Biographers commonly use all these beginnings; however, Lee opened *Virginia Woolf* with a reflection on the process of writing the biography.[37] Then she followed a partly chronological, partly theme-based structure, often moving backwards and forwards in time.[38]

In early drafts of *Breaking through the Pain Barrier*, the prologue explored the cultural history of pain and placed contemporary pain management within a historical, social and political context. The narrative, however, was not sufficiently engaging, and I doubted it would engage the reader. Another option I considered was opening with my decades-long experience of daily migraine attacks and how Cousins's progressive treatment approaches helped me self-manage my condition. At the time, I was reading Gabrielle Jackson's memoir *Pain and Prejudice*[39] about her struggle with endometriosis and her motivation for writing the book.

Jackson's introductory chapter shared her experience of chronic pelvic pain and how it impacted her life. Then she followed with an illustration of her battle with not being believed in a medical system she attested under-served women. In contrast, Madonna King opened *Ian Frazer: The Man Who Saved a Million Lives*[40] with a scene during the immunologist's middle adult years. Frazer, who created the vaccine to prevent cervical cancer, was giving a speech at the Australian Consulate in New York. At the end of the presentation, a young woman jumped from her seat, proposing a toast to Frazer for saving her life seventeen years earlier. After this three-page scene, King observed a chronological structure, starting with Frazer's birth and childhood.

After reading Jackson's memoir and King's biography of Ian Frazer, I drafted a prologue about my experiences with chronic migraine. When I reviewed it, however, I felt uncomfortable because it seemed too self-indulgent, despite the ability of the subjective voice to be a useful narrative device. An added concern was that I doubted the prologue's ability to propel the reader forward. After more experimentation, I drafted the scene at St George Hospital quoted earlier in this chapter, describing the plight of the two burned boys and Cousins's inability to

[37] Lee, *Virginia Woolf*, 3.

[38] Thomas, 'The Art of Biography No. 4 Hermione Lee', 145.

[39] Gabrielle Jackson, *Pain and Prejudice: A Call to Arms for Women and Their Bodies* (London: Hachette, 2019).

[40] King, *Ian Frazer,* vii–ix.

control their pain. Once I reviewed this scene, I realised it would make a compelling prologue, so I replaced my migraine journey with it.

After settling on the prologue, the next challenge was to choose the content of Chapters One, Two and Three. In early drafts, Chapter One examined Cousins's childhood and early influences, Chapter Two explored formative experiences during his teenage years, and Chapter Three recorded his memories of medical school. From then on, the narrative progressed in a combination of chronological and theme-based structures until his retirement. The prologue's drama, however, was not sustained throughout the childhood chapters, and the gap between the inciting incident and main action was too wide. Also, the partially theme-based structure meant the narrative moved backwards and forwards in time, which members of my non-fiction writing group suggested was too confusing.

After much deliberation and experimentation, I removed the childhood chapters because they slowed the story's forward motion. That enabled me to progress from the inciting incident in the prologue to the first chapter, a description of Cousins's experiences as an anaesthesia registrar and his growing understanding of pain and its treatment. From then on, I progressed chronologically, focusing the narrative on life-changing decisions, junctures and decisive moments.

Despite its limited focus on an individual life rather than a group of collaborators, the archetypal hero's journey structure, as described in Chapter One of this exegesis, enabled me to portray Cousins's journey from a junior doctor in Australia to an anaesthetist and pain researcher in North America, followed by several decades of advancing pain medicine in Australia. After removing the childhood chapters, I incorporated childhood influences and formative experiences into the narrative as backstories and flashbacks. This structure also allowed me to provide a snapshot of the history of pain medicine in Australia through the eyes of Cousins and his colleagues, archival sources and the pain medicine literature, providing a framework on which to superimpose climactic moments in Cousins's life story. However, as stated earlier, 'Breaking through the Pain Barrier' is not an exhaustive history of pain medicine in Australia due to space restrictions.

Interpretation

A concept I struggled to grasp in a practical sense was the role of interpretation in biography, a contested issue among biographers and scholars. I was unsure to what extent I should step out of the narrative at critical moments to guide my readers. Should I judge, provide an explicit point of view and explain the meaning of Cousins's contradictions, decisions and behaviour? Or should I leave readers to draw their own conclusions based on the choices I made about which evidence I included, emphasised and suppressed? This decision was complicated because my subject and witnesses were alive and could challenge my interpretation. Another consideration was respecting privacy and reflecting on the ethics of revealing secrets or anything embarrassing or hurtful to a living subject, as discussed in Chapter Three of this exegesis.

Nadel, who wrote *Biography: Fiction, Fact and Form*, describes three types of narrators depending on the extent to which they interpret a subject's life: dramatic/expressive, objective/academic and interpretative/analytic. An expressive narrator emphasises participation and has a symbolic or actual presence in the narrative as a character or commentator. They also have a unique relationship with the subject and often use this for dramatic effect.

In contrast, an objective or academic narrator is more detached and adopts an omniscient voice, relying on 'fact, documentation and record'. This, however, can separate the narrator from the story and risk depersonalising the biography. 'Research replaces experience, and the result is usually a dull but accurate account, a reference book rather than a life story', Nadel explained.[41]

On the contrary, an interpretative biographer is a commentator who guides the reader and establishes the meaning of the material for them.[42] In searching for meaning, interpretative narrators intervene at unexpected moments when they sense the reader requires an analysis of the life.[43]

In 'Breaking through the Pain Barrier', I adopt each of these stances at various points in the narrative. When describing my personal experiences, I am an expressive narrator. My role

[41] Nadel, *Biography: Fiction, Fact and Form*, 172.

[42] Nadel, *Biography: Fiction, Fact and Form*, 171.

[43] Nadel, *Biography: Fiction, Fact and Form*, 173.

changes to academic narrator when describing pain research, as evident in the following extract about the publication of Cousins's textbook, *Neural Blockade in Clinical Anesthesia and Management of Pain.*[44]

> It was the first comprehensive modern textbook on regional anaesthesia and pain and included chapters on the basic pharmacology and physiology of neural blockade, clinical techniques, and their use in pain management.[45]

In the published edition of the biography, I lacked the confidence to act as an interpretative narrator, except in a few places. The principal way I guided the reader was through a painstaking selection of evidence because I believed the narrative choices I made, and which facts I included, emphasised or suppressed, would influence readers' perception of my subject. Most of my interpretation was implicit in the narrative; I preferred to let readers draw their own conclusions rather than telling them mine.

After studying hundreds of documents in the archives during 2022, 2023 and 2024, interviewing detractors and re-interviewing numerous colleagues and associates, I gained the confidence to act as an interpretative narrator. By that stage, I had been working on the project for five years, so I sensed my analysis and judgements were based on a deep knowledge of my subject. An example is my analysis of why Cousins accepted the role at Flinders Medical Centre (FMC) when he did not have a written commitment to establish a multidisciplinary pain centre. Or maybe he did have an agreement and it has been lost during the intervening years?

In a fractious meeting of FMC's department heads and administrators shortly after Cousins arrived, he petitioned for funding to establish a pain centre. The following extracts illustrate my interpretation of the evidence:

> The hospital administrator stiffened, glaring at Cousins. 'Your brief is to create an anaesthetic service in the operating theatre and intensive care unit', he interjected. 'Pain research and a pain clinic are not part of that brief.' This remark accurately reflected the description of the anaesthesia and intensive care service Fraenkel outlined in the 'Preliminary Functional and Policy Brief' he wrote in 1971.[46] The brief did not mention facilities, funding or personnel for pain management.

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[44] Michael Cousins and Phillip Bridenbaugh, eds., *Neural Blockade in Clinical Anesthesia and Management of Pain* (Philadelphia: J.B. Lippincott Company, 1980).

[45] Kelly-Davies, 'Breaking through the Pain Barrier', 172.

[46] Project Planning Office, 'Preliminary Functional and Policy Brief', 20 April 1971, Box 10, Folder 9, Gus Fraenkel Collection, Flinders University (hereafter Fraenkel Collection).

> It is unclear whether Cousins read this brief or other background documents before accepting the role. As someone who painstakingly weighed up the 'pros and cons' while making decisions, it is inconceivable to think he would have accepted the position if he knew building plans did not include a pain clinic and that funding had not been assigned to operate it. Surely, he would have asked questions about the anaesthesia department's budget, facilities and staffing?[47]
>
> …
>
> Equally puzzling questions surround Fraenkel's appointment of Cousins, knowing the young anaesthetist and pain specialist's intentions. Reeve, who knew Fraenkel well because they were both vascular surgeons, claimed Fraenkel knew 'precisely' what Cousins's pain medicine ambitions for FMC were.[48] Did Fraenkel, whom insiders described as fiercely ambitious and manipulative, mislead Cousins, promising him he could establish a pain centre, knowing it was unlikely? According to Kathie Knights, a research officer who later worked with Cousins on anaesthesia toxicity studies, colleagues across the hospital told her about Fraenkel's promises to them regarding resources that never eventuated.[49]
>
> Perhaps Fraenkel agreed to build a pain centre during Cousins's interview but was unable to honour his financial commitments to FMC staff because the state government reneged on its funding promises to the hospital. This is possible given budget cuts across South Australia's hospital system and the FMC's grim financial situation, which was soon revealed.[50]
>
> …
>
> Several colleagues are convinced that Cousins accepted the role knowing the true situation. They suggest that his self-assurance, coupled with the example of his father and brothers and his experiences in North America and at RNSH, convinced him that he could establish and operate a pain centre against all odds.[51]

Visible or Invisible Narrator?

A choice I wrestled with was whether to share my story of living with chronic migraine. It seemed self-indulgent to talk about myself, and I felt self-conscious because of the stigma associated with chronic pain. While contemplating this issue, I studied the academic literature,

[47] Kelly-Davies, 'Breaking through the Pain Barrier', 137.

[48] Reeve, interview.

[49] Knights, interview, 28 August 2023.

[50] Kelly-Davies, 'Breaking through the Pain Barrier', 138.

[51] Kelly-Davies, 'Breaking through the Pain Barrier', 139.

discovering that opinions are divided about the extent to which a biographer should appear in the narrative.

Jay Parini noted that biographers have traditionally remained invisible, 'all-seeing, all-knowing', except of course, James Boswell—to prevent subject bias and ensure objectivity.[52] Today's biographers, though, adopt various roles, including as a fictional character or as an omniscient narrator. Mary Rhiel and David Suchoff, editors of *The Seductions of Biography*, insist: 'The self is not supposed to be in biography at all.'[53] David Marr concurs, insisting on invisibility. 'Biographers should stay out of sight', he declared. 'While there are exceptions, glorious exceptions, biographers should leave their readers alone to read.'[54] Despite taking a strident stand on this issue, Marr admits it is sometimes acceptable for a biographer to be a character in the story if it serves a purpose.[55]

After much deliberation, I included my story because I had lived experience of Cousins as my pain specialist and could speak with authority about him in this context. In addition, I was a member of the pain centre's fundraising committee, so I witnessed his behaviour at monthly meetings, at events with donors, and at the historic National Pain Summit that he orchestrated. Moreover, I planned to include patient stories, so I felt a responsibility to them to share my story. Mostly, though, apart from my personal story of migraine and role as the story's narrator, I remain invisible.

In conclusion, settling on the narrative strategy for the biography involved countless choices and much experimentation, followed by an analysis of the outcome of making each choice. My key learning from this experience is that writing a biography is a process of continual trial and error that involves drafting, redrafting and even rewriting a published book. I took comfort from the acclaimed Australian author Kate Grenville's admission that her biography of her mother, Nance Russell,[56] involved twenty-seven drafts.[57]

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[52] Jay Parini, 'Biography Can Escape the Tyranny of Facts', *Chronicle of Higher Education* 4 (2000): A72.

[53] Mary Rhiel and David Bruce Suchoff, *The Seductions of Biography* (Abingdon, Oxon: Routledge, 2016), 3.

[54] David Marr, 'The Art of Biography', *The Monthly* (December 2016 – January 2016): 4.

[55] Marr, 'The Art of Biography', 6.

[56] Kate Grenville, *One Life: My Mother's Story* (Edinburgh: Canongate Books, 2015).

[57] Susan Wyndham, 'Kate Grenville's New Life as a Single Woman', *Sydney Morning Herald*, 20 March 2015, https://www.smh.com.au/lifestyle/kate-grenvilles-new-life-as-a-single-woman-20150304-13vbim.html.

The next chapter reflects on my learnings as I rewrote *Breaking through the Pain Barrier* after discovering archival sources I could not access because of pandemic restrictions.

Chapter Five: Reflections

Once archives and Australia's state and international borders reopened after pandemic lockdowns ended, I embarked on an intense phase of archival research. The archives held so many surprises about Cousins's character, behaviour and contradictions that I realised I must rewrite the manuscript to reflect new evidence and provide the reader with a deeper understanding of his complexity as a human being. After studying additional archival material, I re-read all the original interview transcripts and Cousins's oral history interviews, which revealed new insights, because, by then, I possessed a much more nuanced appreciation of the historical, social and political context in which he operated. This chapter explores my experience of rewriting the book and the lessons I learned through this process.

The Royal North Shore Hospital (RNSH) archive contains dozens of letters between Cousins and the hospital's medical superintendent during 1973, 1974 and 1975. This correspondence highlights his compassion as a young anaesthetist and pain researcher; however, it also reveals him as audacious and ambitious. While a few colleagues briefly touched on these traits in interviews between 2019 and 2021, they usually laughed them off, sharing amusing anecdotes about them. Until I read the trove of letters, I had not realised the magnitude of these character traits, especially early in his career. His missives display an extraordinary level of self-belief, a single-minded determination to pursue his vision and a willingness to upset the status quo, regardless of whether it alienated his superiors and associates.

In the interviews I conducted before the original biography was published, colleagues were reluctant to criticise Cousins, despite my probing, so, armed with evidence from the RNSH archive, I re-interviewed many of them. They confirmed that the traits I noticed were strong features of his character, ones he would draw on throughout his career to overcome overwhelming obstacles. Most colleagues overlooked these attributes, insisting that without them Cousins would not have been able to overcome chronic financial constraints, strident opposition and political and systemic inertia.

Similar revelations awaited me in the Gus Fraenkel Collection at Flinders University. While studying correspondence, funding proposals, minutes of meetings and reports, I felt the pressure boiling up inside Cousins and his sense of despair as his efforts were thwarted. During four years of research, I had never experienced this level of empathy for my subject, perhaps

because I strove to remain detached and impartial. Before studying the Flinders archives, I knew Cousins overcame formidable obstacles to achieve his goals, but it was only by reading letters and memoranda he wrote and received, and his remarks during meetings, that I fully comprehended the level of his frustration and despair.

Annual reports and minutes of meetings enabled me to track Flinders Medical Centre's (FMC's) bleak financial situation year by year, providing the backdrop to Cousins's struggles, as seen in the following excerpts:

> In late 1977, FMC's third phase of construction was completed, adding extra wards for in-patients. Unfortunately, a $2 million funding shortfall and a strict freeze on staff recruitment resulted in only 360 of the 510 beds being opened to patients. The earliest these beds could be opened would be, at best, two years later, when a state election was due, and funding increases were envisaged in the lead-up to the campaign launch.
>
> Funding was so constrained that Phase Four, the final building phase, was also postponed indefinitely, reducing FMC's bed capacity and delaying the establishment of several critical departments, such as ophthalmology and haematology. Accommodation was so limited, that the space allocation committee considered offering the professor of ophthalmology the staff tearoom as his office![1]

It was revelatory to witness Cousins sidestepping FMC's chiefs when he appealed directly to the state health minister to secure funding to construct a pain centre. Two of his colleagues had described his habit of going around or over the heads of anyone blocking him, but witnessing firsthand his skilful political manoeuvring in letters from one day to the next provided fresh perceptions of him. It enabled me to write the following passages, which reveal how, after eight years of being thwarted, he circumvented his superiors by petitioning John Cornwall, South Australia's health minister, to fund a dedicated pain unit:

> On 23 July 1984, Cousins, FMC's director of nursing and an associate professor in surgery wrote a memorandum to the hospital's administrator, J. M. Blandford: 'You are now aware of the fact that the Pain Management Unit has been operating under makeshift and highly unsatisfactory conditions for the last eight years.' In deeply empathetic and passionate terms, they reiterated Cousins's inexorable pleas about the unsuitability of treating pain unit patients in the recovery area of the operating

[1] Norman Popplewell to K. J. Hancock, 14 August 1978, Box 11, Folder 7, Fraenkel Collection; G. Fraenkel, 'Notes of a Meeting Between B. Shea, G. Fraenkel and A.W. Rogers in the Office of the Chairman of the Health Commission on 24 July 1978', Board of Management Constitution, FMC, 2, Fraenkel Collection; Kelly-Davies, 'Breaking through the Pain Barrier', 164.

theatres, the 'temporary' day surgery unit and scientific laboratories. The memorandum implored:

> On the basis of an existing patient load, the inability of current inpatient and outpatient facilities to cope with the workload and on humanitarian grounds of providing a more appropriate service for patients who have endured great suffering, we strongly recommend an appropriate area be developed specifically for the treatment of patients with chronic, intractable pain.[2]
>
> …
>
> Dialling up the pressure, four days later, a memorandum to Blandford signed by Cousins and Cherry, reminded him of the urgent need for a dedicated area for the Pain Management Unit. 'You will be aware of the strong support from the South Australian Minister for Health and the Health Commission in providing funds for the facility', they wrote.[3]
>
> …
>
> Soon thereafter, the South Australian Health Commission provided a $355,000 capital grant plus equipment to FMC, supplemented by $100,000 from the hospital's volunteer service, equivalent to $1.3 million today. Within weeks, the planning and development committee commissioned an architect to design a state-of-the-art interdisciplinary pain management facility and construction soon commenced. John Cornwall, with Ronald Melzack in attendance, launched the unit on 26 August 1985.[4]
>
> …
>
> Finally, his relentless eight-year crusade had paid dividends. Perhaps when Fraenkel appointed him, he sensed the young anaesthetist's ambition, audacity and powers of persuasion would enable him to realise his vision against all odds?[5]

While studying FMC's annual reports, minutes of planning, space allocation and budget committee meetings, and building plans for FMC, I gained a deeper understanding of the historical, social and political context in which Cousins operated, the reasons his efforts to

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[2] MJC, Villis Marshall and Miss Aileen Monck, memorandum to J. M Blandford, FMC administrator, 23 July 1984, Box 12, Folder 4, Fraenkel Collection; Kelly-Davies, 'Breaking through the Pain Barrier', 192.

[3] MJC and David Cherry, memorandum to J. M. Blandford, 27 July 1984, Box 12, Folder 4, Fraenkel Collection; Kelly-Davies, 'Breaking through the Pain Barrier', 193.

[4] *FMC Annual Report 1985*, 6, Fraenkel Collection; Kelly-Davies, 'Breaking through the Pain Barrier', 194–195.

[5] Kelly-Davies, 'Breaking through the Pain Barrier', 195.

establish a pain centre were opposed, and why, in desperation, he appealed to higher powers to achieve his goals.

Due to the COVID-19 pandemic, it was not until May 2023 that I could visit North America to conduct archival research and retrace Cousins's footsteps. At the John C. Liebeskind History of Pain Collection, History & Special Collections Division, Louise M. Darling Biomedical Library, University of California, Los Angeles, I observed week by week, month by month, year by year the early pain pioneers building the field of pain medicine during the 1970s, 1980s and 1990s. Hundreds of letters, memoranda, minutes of meetings and financial statements reveal how they established and funded the IASP, the early days of the association and the extraordinary effort it required from its leaders to create a new field of medicine.

Many of the letters were multi-page analyses of draft chapters of the textbooks Cousins edited with collaborators such as Phillip Bridenbaugh. Reading the letters revealed his exacting workload while liaising with the books' contributors. The following extracts from 'Breaking through the Pain Barrier', are based on letters Bonica wrote to Cousins while they were both updating their textbooks, a task Bonica bemoaned as 'very onerous and time-consuming'.[6]

> A frequent theme of Bonica's letters was the punishing workload of crafting the second edition of *The Management of Pain*, which he claimed, consumed eighty hours each week.[7] His remarks provide an indication of the pressure Cousins, too, experienced as he juggled so many commitments while updating *Neural Blockade*, though he never mentioned this issue in his letters to Bonica. 'You began the second edition of your volume long after I initiated the second edition of the *Management of Pain*', Bonica wrote in 1986, 'and you are way, way ahead of me'.[8]
>
> 'In addition to writing about 65% of the text and developing virtually all of the illustrations', Bonica wrote three years later, 'I have had to spend considerable time to amplify, add, edit, correct, revise, etc of other chapters. I know that you have had this kind of experience and appreciate the work that goes into trying to put other people's chapters into high quality material!'[9]

[6] JJB to MJC, 28 August 1989, Box 2, Folder 29, Bonica Papers.

[7] JJB to MJC, 2 May 1984, Box 2, Folder 29, Bonica Papers.

[8] JJB to MJC, 26 March 1986, Box 2, Folder 29, Bonica Papers; 'Breaking through the Pain Barrier', 209-210.

[9] JJB to MJC, 28 August 1989, Box 2, Folder 29, Bonica Papers; Kelly-Davies, 'Breaking through the Pain Barrier', 210.

Letters between Bonica, and IASP's leaders demonstrate the organisation's internal culture and politics and disagreements among members, particularly a lack of consensus on issues such as terminology, ethical standards, clinical guidelines and education and training.

A series of oral history interviews with IASP's leaders also included surprising insights into Cousins's behaviour and how his IASP colleagues perceived him. Bonica was domineering and intimidated most colleagues, yet even Bonica remarked on Cousins's indomitable will:

> 'I like Mike very much', Bonica remarked, 'but he wanted to be the boss. He wanted to have everything under his wing'. John Liebeskind shared this view, noting the intense 'currents and cross-currents' swirling through the IASP membership and Cousins's politicking behind the scenes to achieve his goals.[10]

> A few years after Bonica retired, Ronald Melzack was eager for him to return to IASP's Council. 'Mike didn't say no', Melzack recalled:

> but what he said was the young guys like him would feel like they were taking a major step backwards. He saw himself as the young Turk who was going to overthrow all those stupid old ideas or whatever the hell he was trying to fight. I don't know what battles he was fighting then.[11]

Walking in Cousins's footsteps in North America was also revealing. One place that still looked as it had when he was there in 1969 was the austere Royal Victoria Hospital in Montreal, where he first practised pain medicine. Daniel Chartrand, 'Royal Vic's' vice-chair of anaesthesia and former chair of the archives and artefacts committee of the Canadian Anaesthesia Society, escorted me around the Gothic hospital, which was built in 1893.

During the tour, I saw the office Cousins shared with other pain researchers and the operating theatre where he conducted his first study on epidural anaesthesia. In one of our interviews, Cousins had described his feelings during this experiment, and as I sat in the chilly operating theatre, I felt his exhilaration as he embarked on his career in the world's pre-eminent centre for regional anaesthesia. Chartrand also emailed me a copy of *Anaesthesia at McGill: With a Flame of Passionate Idealism*,[12] a history of McGill University's anaesthesia department, to which Cousins contributed a chapter detailing his memories.

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[10] JJB, Interview by John C. Liebeskind. 9–12 March 1993, 133. John C. Liebeskind History of Pain Collection, History & Special Collections Division, Louise M. Darling Biomedical Library, University of California, Los Angeles; Kelly-Davies, 'Breaking through the Pain Barrier', 205.

[11] Ronald Melzack, interview by John Liebeskind, 16 October 1993, Liebeskind Collection, 61; Kelly-Davies, 'Breaking through the Pain Barrier', 205.

[12] Harold Davenport, *Anaesthesia at McGill: With a Flame of Passionate Idealism* (Montreal: McGill University, 1996), 66–69, Daniel Chartrand Private Collection.

With the benefit of hindsight, I should have waited for the pandemic to reach its uncertain end before publishing the biography. I had assumed that extensive research in the ANZCA and FPM archives; analysis of oral history interviews, the pain medicine literature and media coverage; and interviews with a multiplicity of witnesses was a sufficient wealth of evidence to explain my subject's character and behaviour. Clearly, I was wrong. Archival material from FMC, RNSH and the John C. Liebeskind History of Pain Collection revealed vital clues about Cousins I had not fully grasped.

My learnings while researching, drafting, publishing and rewriting *Breaking through the Pain Barrier* and researching and crafting 'Choices, Choices, Choices' are immense, as I have recounted throughout this exegesis. A crucial lesson was the imperative to follow Robert Caro's advice to 'turn every page and never assume anything'[13]—one I will draw on in my future biographical endeavours.

One of my key realisations is the power of biography to examine an individual's life within the broader context of history, culture, politics and social dynamics. A biography extends beyond an individual life to reflect cultural norms, societal values and prevailing ideologies. Vitally, the genre reflects a dynamic interplay between character—which drives the plot—and context.

Another learning is that driving innovation comes at a cost to an individual and those close to them. A subject's willingness to accept these sacrifices reveals much about their character and personality. A biographer's task is to reveal what it took for the subject to succeed, their impact and what was at stake.

When we take a medication or undergo a medical procedure, we do not think about the person who developed the treatment and what price they paid to provide us with a solution to our medical condition. This is one of the benefits of biographies of scientists and doctors because they reveal the human story within the historical context underpinning scientific and medical progress. Many of these character-driven narratives depict struggle, personal sacrifice, perseverance and resilience that illuminate the interplay between scientific advancement and a subject's psychological complexity and humanity.

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[13] 'Turn Every Page: Inside the Robert A. Caro Archive', New York Historical Society Museum and Library, 2021, accessed 5 June 2022, https://www.nyhistory.org/exhibitions/turn-every-page-inside-robert-caro-archive.

Biography offers a lens through which to explore scientific passion, tracing the evolution of a researcher's ideas, scientific endeavours and philosophical perspectives over time. At its core, science and medical biography studies an individual's intellectual and personal journey as they make groundbreaking discoveries. It also illuminates the professional and societal resistance trailblazers face. By exploring a scientist's courage and perseverance in the face of scepticism, readers gain a deeper understanding of the obstacles encountered by those who challenge the status quo and fuel medical and scientific innovation.

One potential impact of science biography is inspiring future generations to follow in a biographical subject's footsteps. Examining a researcher's methods, collaborations and challenges provides valuable insights for young scientists. Equally, aspiring leaders in any field can learn from the experiences of scientific leaders as they navigate the challenges involved in embracing innovation and change.

Crucially, biographies of pioneers are a potent tool in the history of science and medicine, illuminating the complex interplay between character, science and society.

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PART II Biography

Breaking through the Pain Barrier: The Extraordinary Life of Dr Michael J. Cousins

Prologue

It is cracker night[i] in 1964 and thousands of kids across New South Wales squeal with delight every time a skyrocket blasts into the air, spraying a rainbow of colours high above their heads. Once the thrill of the skyrocket wears off, they light a double bunger that makes an ear-splitting racket when it explodes.

Later that night, a tall, athletic young man with glossy dark hair stands in front of St George Hospital's Casualty Department. His eyes are fixed on the entrance to the hospital's driveway. That young man is Dr Michael J. Cousins.

He finished medical school twelve months earlier and is now a resident medical officer at St George Hospital in southern Sydney. At this stage of his career, he does not know which medical speciality to pursue and often worries he might never find an area of medicine that is right for him.

Suddenly, he hears heart-wrenching screams from the end of the driveway. Swivelling his head towards the sound, he notices two tiny, blackened figures limping up the path.

He sprints towards the children, the edges of his white coat flapping in the wind, his stethoscope swinging around his neck. As he gets closer, he realises they are the two burned boys he was waiting for in the ambulance bay. He notes the skin on the boys' faces is black and the skin on their heads, torso, arms and legs looks completely burned off. The boys wail, and their blackened hair stands on end, making it look fuzzy.

Once the boys are inside, Cousins gently inserts needles into the backs of their burned hands. The needles are attached to drips. Their hands balloon and he is glad he got the cannulas in on time—any later and the swelling would have prevented it. First, he runs tiny doses of morphine through the drips, then places oxygen masks over the boys' scorched faces. The morphine, however, does not work. The children's piercing screams reverberate through the Casualty Department.

For the next forty-eight hours, Cousins and the hospital's medical and nursing team keep a vigil by the boys' bedsides. Thankfully, the children survive; however, the staff fail to ease their horrific pain.

Haunted by the boys' suffering, Cousins resolves to learn more about pain and its treatment, a fifty-year quest that will see him face seemingly insurmountable obstacles, make countless personal sacrifices, reach the heights of the nascent pain world and consume every waking moment.

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I first met Michael Cousins after my general practitioner referred me to the pain clinic at Sydney's Royal North Shore Hospital (RNSH) for treatment of daily migraine attacks that started after some young men passing in a speeding car lent out of their window and pushed me off my bicycle. The force of impact was so strong that I rolled along the road, pivoting on my neck. For the next two decades, I ricocheted from specialist to specialist on the medical merry-go-round, migraine attacks my constant, unwelcome companion.

A warm, compassionate doctor, Cousins truly listened to me—unlike the countless medical and allied health professionals who had dismissed me as a hopeless case or, worse still, a hypochondriac and 'drug seeker'. During visits to the pain clinic and, later, as a member of the pain centre's fundraising committee, I learned that Cousins's empathetic manner with patients was just one aspect of his complex, contradictory character. Within university, medical and political circles, he was an audacious and savvy political operator and a formidable negotiator. These paradoxes sparked my curiosity about who he was as a person, how he reconciled the conflicting aspects of his character and what drove him to sacrifice so much to achieve his vision of reducing suffering by improving the treatment of pain. This was my inspiration for writing his story.

Chapter One: Learning about Pain

Michael Cousins had felt 'out of his depth' trying to reduce the boys' suffering and had realised that his medical training had not equipped him to control such severe pain. 'I guess it impressed on me the need to have something a lot better', he recalled. Unsure how to specialise in pain, he asked the senior doctors at his hospital about it. Pain was such a new field of medicine that few people knew about it. His colleagues suggested he train as an anaesthetist because, in the 1960s, it was anaesthetists who treated patients with excruciating pain. 'It didn't take me long to realise that to find the right spot for me in medicine, I needed to get onto the road of anaesthesia training.'

In January 1965, six months after treating the burned boys, Cousins joined RNSH in northern Sydney as an anaesthesia registrar. He felt 'at home' at the hospital because he often bumped into his mother Marjorie in the lift or corridors—she worked there as a volunteer. His clinical placements during medical school had been at the hospital and, during university holidays, he had worked there as a porter in the chest surgery ward.

As a fourteen year old, he had been a patient at RNSH after he broke his nose playing rugby and required surgery. This experience had inspired him to study medicine,[i] though an earlier incident might also have been a formative influence. When Cousins was ten years old, his next-door neighbour, an 'erudite gentleman', gave him a copy of the surgeon John Hilton's classic book *Rest and Pain.*[1] It was a series of lectures on anatomy and pain Hilton delivered between 1860 and 1862.[ii] 'That book fascinated me', Cousins remembered, but he did not know why his neighbour had given him the book.

On his first day as a registrar, Cousins treated several patients in the Casualty Department. One, a tall, muscular man in his thirties, walked stiffly and had sagging shoulders.

'I've had pain in my back for two years', the man said, grimacing. 'It's so bad it keeps me awake at night. I've seen several doctors, but none of their treatments work.'

At that stage, Cousins did not know how to reduce the patient's pain; however, he was determined to find a way. Every time he had a spare minute, he read textbooks and spoke with

[1] John Hilton, *Rest and Pain*, 6th ed. (Philadelphia: J. B. Lippincott Co., 1950).

RNSH professors. As the months passed by, he met many patients like the man he saw on his first day. He worried about them. Patient after patient told him how their general practitioner had sent them to a specialist who referred them to another specialist. Unfortunately, none of the treatments the doctors suggested decreased their suffering.

One reason he empathised with his patients was his own experience of unrelenting pain. As a young boy, he had suffered agonising abdominal cramps. Sometimes the pain had hit him on his way to school; it could be so intense that he doubled up, dropping into the gutter until it eased. The problem continued during his teenage years and still affected him as an adult. He, too, had seen specialist after specialist; however, no-one could offer him any relief.

Other than bouts of abdominal pain, he had been a robust child and a talented athlete at Sydney Church of England Grammar School in North Sydney,[iii] where he represented 'Shore' in athletics, rugby and rowing (see Figure 1) at The Great Public Schools (GPS) competitions. A talented sprinter, he broke the GPS record for the quarter mile; however, much to his disappointment, another boy was even faster, so Cousins did not win the race.

Figure 1: Shore rowing regatta 1955. Michael Cousins is second person from the left.

Courtesy Michael and Michele Cousins.

Every night Cousins had joined his childhood friends Ray Chapman and Fergus Munro for athletic training in Chapman's backyard. Their regimen included a series of strenuous calisthenics, weight training, throwing shot-puts and sprints.[2] Cousins was so determined to succeed, he diligently saved his pocket money towards buying handmade running shoes with

[2] Ray Chapman, interview by Gabriella Kelly-Davies (hereafter GKD), 28 May 2020; Fergus Ryan, interview by GKD, 28 May 2020.

spikes from a specialist shoemaker in Sydney.[iv] Based on the advice of Olympic swimming coach Forbes Carlile,[3] he also maintained a strict diet, avoiding any food that would not enhance his performance—his only exception was his mother's irresistible, ultra-sweet caramel tart. So, his cramps remained a mystery to everyone concerned.

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Every night after finishing work at RNSH, Cousins would race home to read journal articles about pain. He was saving to buy a flat, so he lived with his parents, Marjorie and Hedley Cousins, and brother Geoff in a small house on Sydney's affluent upper North Shore. Geoff, three years his junior, said they enjoyed a harmonious relationship and never fought, which is unusual for boys, especially because they shared a bedroom until Cousins was thirteen. The pair shared a love of tennis, rugby and athletics, though the tennis court was often the scene of 'high competition', as Cousins set out to beat Geoff at every match, a habit that would continue into his sixties.[4]

Figure 2: Geoff and Michael Cousins, 1945.

Courtesy Michael and Michele Cousins.

Cousins and Geoff had two older siblings from Hedley's first marriage. When Cousins was born on 17 November 1939, two months after the start of World War II, his older brother Keith was fourteen and his older sister Pam eleven. The two younger Cousins boys referred to them as Uncle Keith and Aunty Pam, not knowing they were their half-brother and sister until someone mentioned it at a wedding anniversary dinner for Marjorie and Hedley when they

[3] Forbes Carlile, *Training for All Sports* (Sydney: Dymock's Book Arcade, 1950).

[4] Geoff Cousins, interview by GKD, 24 September 2019.

were teenagers. Tragically, Keith and Pam's mother, Lavinia, had died of tuberculosis at the age of thirty-one.

A loving mother, Marjorie was the controlling influence and disciplinarian in her home. Tall and slim with short brown hair, she enjoyed playing golf and was an accomplished tennis player. She was also active in the community and was known locally as a 'change agent'. Her ability to identify an issue, take action with confidence and conviction, and bring about change was a trait shared by others in Cousins's extended family, and it was deeply ingrained in him from an early age. The self-belief and confidence he exuded from childhood would be a hallmark of his character throughout his life.[5]

Hedley Leunig Cousins—a 'gentlemanly' figure, according to his sons—was tall and wore glasses. Distinguished looking, he spoke with his hands, enthusiastically gesturing during every conversation. He loved smoking his pipe and family folklore suggests he smoked it upside down in the shower. Personable and kind, Hedley was not religious, instead living by a high ethical code he would instil in Cousins.[v] Marjorie, Hedley and several members of their extended family lived with a strong moral compass, and they served as role models for the young Cousins, whose upbringing was conservative and conventional. Even as a young child, he had a strong sense of right and wrong and would admonish Geoff if he believed his younger brother's behaviour was 'out of line'.[vi]

Hedley did not hold firm political beliefs or strong opinions on social issues, which is surprising given the paths his three sons followed.[vii] A founding partner of the independent advertising agency Jackson Wain,[viii] he quickly climbed the corporate ladder because of his exceptional communication skills. In 1963, he expanded Jackson Wain into overseas markets by establishing the company's office in Park Lane, London, to manage the Qantas account.[6] Marjorie, a dedicated Anglophile, revelled in this period of their lives. One of the creative directors on the Qantas account was Donald Horne, a public intellectual who wrote the legendary book *The Lucky Country: Australia in the Sixties.*[7]

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[5] Chapman, interview; Ryan, interview.

[6] Robert Crawford and Jackie Dickenson, *Behind Glass Doors: The World of Australian Advertising Agencies 1959–1989* (Perth: UWA Publishing, 2016), 67.

[7] Donald Horne, *The Lucky Country: Australia in the Sixties* (London: Angus & Robertson, 1968).

Even as children, Hedley's three sons were consummate communicators, according to childhood friends.[ix] During interviews in 2019, Cousins and Geoff could not remember whether their father consciously taught them this skill or whether they learned it subliminally: was it inherited or a mix of nature and nurture?[8] Regardless, their communication skills would serve them extremely well throughout their careers.

Once learning about pain became his mission, Cousins spent his evenings 'buried in books'. Every night, immediately after dinner with his parents and Geoff, he headed to the makeshift study he had created under his family's bungalow. Bookshelves filled with dog-eared textbooks lined the walls, and white index cards covered in tiny writing and anatomical illustrations littered his desk. Sitting at his oak desk late into the night, he searched for clues on how to reduce his patients' pain.

One night he read that an authoritative textbook had been written on pain. *I must find it*, he thought, impatient to read it. He scribbled the book's details in a notebook then placed it in his battered leather briefcase.

At the 'crack of dawn' the following Saturday, Cousins jolted awake, even though his last shift for the week had ended only a few hours earlier. After a breakfast of wheatgerm and black strap molasses—'terrible stuff' that Forbes Carlile claimed increased athletic performance[9]—Cousins drove to the University of Sydney's Medical School, a Gothic sandstone building with stained-glass windows.[10] Checking his watch every few minutes, he stood outside the library's highly varnished, dark wooden doors.

On the dot of nine o'clock, a small woman with bobbed grey hair and round glasses opened the doors. Smelling the familiar musty odour brought back memories of spending long hours studying in the library. Heading straight to the catalogue, a series of wooden drawers filled with white index cards, he looked up 'B'.

'Yes! He's here', Cousins remembers, gasping, barely able to contain his excitement.

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[8] Geoff Cousins, interview by GKD, 24 September 2019.

[9] Carlile, *Training for All Sports*.

[10] The medical school was originally in the Anderson Stuart Building, 'a sandstone masterpiece' according to Richmond Jeremy. Cited in Ann Jervie Sefton, Yvonne E. Cossart and Louise Freckelton, *150 Years of the Faculty of Medicine* (Sydney: Sydney University Press, 2006), 279.

He had found Professor John J. Bonica's magnum opus, *The Management of Pain*[11]—the only book that discussed everything known about pain and its treatment.[x] After 'making a beeline' for the shelf that held the key to his future, he hurriedly scanned the call numbers. Fifty years later, he still recalled his heart pounding against his chest wall as he glimpsed the bulky tome. After pulling it from the shelf, he carried it to a vacant desk. At the same time as he pulled out a chair, he opened the book and tried to read it. After checking the index and finding the right section, he ran his finger down each page, line by line.

He read that Bonica, an anaesthetist, had launched a pioneering pain centre in America in the 1940s and that one way he treated his patients' pain was by injecting local anaesthetic onto a nerve to numb it. This technique was known as nerve block or neural blockade.[12] Cousins decided to try it on several patients who had endured years of unrelenting pain. It was the beginning of his passion for neural blockade research.

Cousins was surprised to learn that the ideas of the seventeenth-century philosopher René Descartes still influenced pain treatments in the 1960s.[13] Descartes believed that the nervous system acted like a telephone cable, with electrical impulses running from the surface of the skin to the spinal cord then up to a dedicated pain centre in the brain. It astonished Cousins to discover that knowledge about pain had progressed little during the previous three centuries, and he wondered how Descartes's theory applied to his patients suffering from persistent pain. He resolved to find out.

Bonica's textbook was in the reference section and not free to borrow, so Cousins spent the weekend in the library studying it. The library felt like a second home to him; he had studied medicine at the University of Sydney for six years from 1958 and had often revised his lecture notes in the library before exams. A conscientious student, he had been afraid he would be among the 'two-thirds' of students who failed each year.[xi] 'I worried I hadn't done enough', he admitted, frowning. 'If I failed the exam at the end of the year—out.'[xii]

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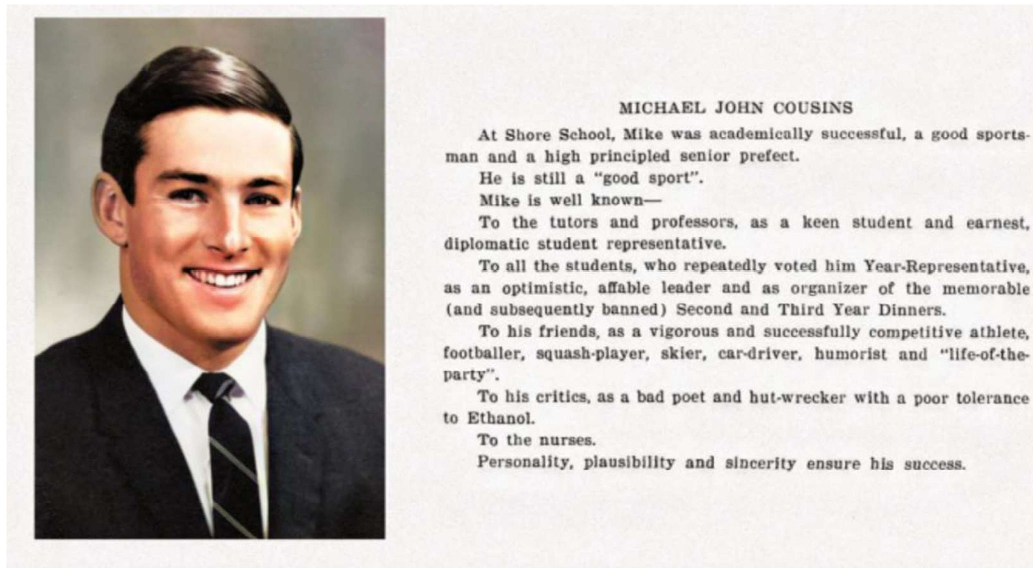
[11] John J. Bonica, *The Management of Pain* (Philadelphia: Lea & Febiger, 1953).

[12] A nerve block involves injecting local anaesthetic along the course of a nerve to relieve pain. Peter Harris, Sue Nagy and Nicholas Vardaxis, eds, *Mosby's Dictionary of Medicine, Nursing and Health Professions* (Sydney: Elsevier Health Sciences, 2019), 414.

[13] Ronald Melzack, 'Pain: Past, Present and Future', *Canadian Journal of Experimental Psychology* 47, no. 4 (1993): 615.

Nevertheless, as a student, he had enjoyed socialising and was sometimes ‘distracted by the nurses’, whose highly starched, tight-waisted uniforms attracted his attention. Notorious for poking his head through the open windows of Fergus’s and Ray’s bedrooms in the middle of the night, he would whisper loudly: ‘Get up. There’s a terrific party on!’[14]



MICHAEL JOHN COUSINS

At Shore School, Mike was academically successful, a good sportsman and a high principled senior prefect.

He is still a "good sport".

Mike is well known—

To the tutors and professors, as a keen student and earnest, diplomatic student representative.

To all the students, who repeatedly voted him Year-Representative, as an optimistic, affable leader and as organizer of the memorable (and subsequently banned) Second and Third Year Dinners.

To his friends, as a vigorous and successfully competitive athlete, footballer, squash-player, skier, car-driver, humorist and "life-of-the-party".

To his critics, as a bad poet and hut-wrecker with a poor tolerance to Ethanol.

To the nurses.

Personality, plausibility and sincerity ensure his success.

Figure 3: Michael John Cousins, University of Sydney, 1961.[15]

Courtesy Michael and Michele Cousins.

During his first months as a registrar, he woke up energised most days, despite often working thirty-six-hour shifts.[xiii] At his core, he was ‘bone-tired’, and his clothes reeked of anaesthetic gas from spending so many hours in the poorly ventilated operating theatres. Still, his determination to learn more about pain drove him. Worried that so many of his patients complained about their unremitting pain, he longed to offer them more relief than was available. His relentless search for clues continued, becoming a lifelong habit.

One of RNSH’s doctors who was drawn to Cousins because of this tendency was Tom Reeve, a vascular surgeon and RNSH’s inaugural professor of surgery. The pair often chatted when Reeve conducted procedures, such as varicose vein surgery, and Cousins anaesthetised his patients. Cousins, who thought of Reeve as an ‘old school professor and a gentleman’, said he modelled his behaviour on that of his ‘mentor’. Reeve admired the anaesthesia registrar’s

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[14] Chapman, interview; Ryan, interview.

[15] Margaret Blaket, ed. *Senior Year Book: Faculty of Medicine, University of Sydney* (Sydney: Sydney University Medical Society, 1963), 119, Michael John Cousins Private Collection (hereafter MJC Private Collection).

empathy for patients, inexhaustible enthusiasm and drive to find answers to medical problems. 'Michael had ideas all the time, and he put them to the test', Reeve said in an interview at the age of ninety-nine, just a few months before his hundredth birthday and death. 'Of single purpose, he was always right on the ball and at the cutting edge.'[16] Perhaps they were kindred spirits because they were both prepared to 'rock the boat' to ensure the best possible patient care.[17]

One day after an operation, Reeve took his anaesthesia colleague aside. 'I'm disappointed when some of my patients wake up from surgery shivering and in pain', Reeve said in his warm, gentle voice. Cousins nodded because he knew shivering caused the arteries and veins to narrow. If this happened after surgery, it could stop blood flowing into the fresh blood vessel graft, and the graft could die. Reeve asked Cousins if he had learned about 'the shivering problem' at medical school. Cousins shook his head, promising to research the issue.

During the following week, Cousins stayed up late searching medical journals for answers, and he found articles by McGill University's Philip Bromage, the doyen of regional anaesthesia,[18] particularly epidural anaesthesia. Bromage described how he had injected local anaesthetic into the epidural space—the space surrounding the outer membrane of the spinal cord—to relieve pain after patients had crushed their chests in an accident.[19] This procedure reduced the patient's discomfort, enabling them to cough, remove any secretions from their lungs and recover faster. This approach 'struck a chord' with Cousins because of his interest in improving pain management after varicose vein operations.[20] He wondered if local anaesthetic injected into the epidural space might reduce shivering and pain after blood vessel surgery.

The next day, he hurried to the hospital and 'scouted around' for Reeve. When he found him, he said: 'I've been thinking about the shivering problem. Running local anaesthetic into the

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[16] Tom Reeve, interview by GKD, 28 September 2022.

[17] Fran Boyle, interview by GKD, 12 January 2024.

[18] Regional anaesthesia involves injecting local anaesthetic into a group of nerve fibres to relieve pain. Harris, Nagy and Vardaxis, *Mosby's Dictionary of Medicine*, 1484.

[19] Epidural anaesthesia/analgesia involves injecting local anaesthetic into the epidural space, which surrounds the dura—the outermost and fibrous of the three membranes surrounding the brain and spinal cord. Harris, Nagy and Vardaxis, *Mosby's Dictionary of Medicine*, 560.

[20] Harold Davenport, *Anaesthesia at McGill: With a Flame of Passionate Idealism* (Montreal: McGill University, 1996), 66.

epidural space after the operation might help. It could continue the effects of the epidural anaesthetic given during surgery.'

Despite it being an unorthodox idea, Reeve was eager to test it, so Cousins set up a 'rather primitive drip method' of continual epidural analgesia for patients who had undergone blood vessel surgery.[21] He and Reeve were astonished that fewer patients shivered after their operation and more of Reeve's blood vessel grafts survived. This result intrigued Cousins and he started dreaming up ideas for research projects that might help him discover why the postoperative epidural analgesia had reduced shivering. He was also eager to find a more advanced delivery mechanism than the basic drip method.

Around the same time, Cousins met Michele Old at a Christmas party. Like him, Michele had grown up in a conservative, upper-middle-class family in Killara, and she too had attended an elite private school. Her father, Trenham, owned a leading Sydney law firm, and her mother, Poppy, was a dedicated homemaker. Marjorie Cousins and Poppy regularly played bridge together, and they had orchestrated the meeting between their son and daughter.

Michele had just finished an arts degree at the University of Sydney, and she was a member of the university's ski team. Petite, with golden blonde hair and translucent blue eyes, she worked as a research assistant at the university's law school, where her father regularly taught. Michele 'took one look' at Cousins's warm hazel eyes and friendly smile and instinctively knew they would marry. Cousins felt the same way. 'It felt as if we'd known each other all our lives. It was most peculiar, as it happened in an instant', he stated. He drove Michele home and invited her to dinner the next evening. To his dismay, however, he was forced to wait six anxious days for his date because Michele was busy with pre-Christmas festivities.

Two weeks after meeting Michele, Cousins asked her to marry him. To his delight, she accepted. Down at Michele's parents' holiday home at Palm Beach two weeks later, Cousins seized the moment, asking Michele's father, Trenham, for permission to marry his daughter.

Trenham looked startled. 'You haven't known each other very long, have you?' he asked, accidentally pouring Poppy a glass of whisky AND brandy. Nevertheless, he agreed to his future son-in-law's request.

[21] Davenport, *Anaesthesia at McGill*, 66.

Cousins agreed that asking Michele to marry him so soon was the rashest decision of his life and out of character for him. His usual practice was to think carefully about decisions, drawing up an exhaustive list of 'pros and cons' and agonising about each of them. In marrying Michele, however, he insisted 'it was not really a decision because I knew she was the right one from the moment I met her'.[22]

The couple waited until the end of March 1967 to announce their engagement because Cousins was determined to pass the first part of the anaesthesia fellowship exam, and he did not want any distractions to disturb his study schedule. For several long weeks, he studied 'flat out' whenever he was not working at the hospital. Immediately after the exam, and one week before Marjorie and Hedley were due to leave for a seven-month trip overseas, the pair's parents hosted two engagement parties: one at Michele's gracious childhood home in Killara and another at Cousins's house two kilometres away. On 29 March 1967, the *Australian Women's Weekly* magazine published an announcement about the couple's engagement in its 'Social Roundabout' column.[23]

Figure 4: Michael Cousins and Michele Old, 1967.

Courtesy Michael and Michele Cousins.

For the next seven months, while waiting for Marjorie and Hedley to return, the duo dated whenever Cousins had a break from work and study. Cousins yearned to spend more time with Michele and missed her when they were apart. Nevertheless, they enjoyed the occasional movie or party, and they loved attending Sydney Symphony Orchestra concerts at the Sydney Town

[22] MJC, interview with GKD, 27 February 2019.

[23] Mollie Lyons, 'Social Roundabout', *Australian Women's Weekly*, 29 March 1967, 13.

Hall. They also skied during winter—Michele relished the perilous black runs. Her fiancée was also 'game', though he preferred to 'play it safe' on less risky slopes.

Ten days after Hedley and Marjorie Cousins arrived home—on 27 October 1967—Cousins and Michele married at St Martins Anglican Church, Killara. They had both been Christened and confirmed there. Cousins was twenty-eight and Michele was twenty-three. His eyes filled with tears, and he caught his breath as he watched Michele enter through the church's heavy wooden doors then gracefully walk up the aisle. She wore a white double silk organza dress with three-quarter length sleeves and a modest scoop neck. His suit had black tails and he wore a white bowtie and white gloves.

The next day, the newlyweds flew to Noumea for their honeymoon. They loved the blue lagoons and crystal clear waters of the island, and they spent blissful days swimming, snorkelling and sailing. It was the most time they had spent together since meeting the previous year.

When the couple returned from their honeymoon, they moved into Granny Cousins's furnished unit in Werona Avenue, Gordon. To their delight, Cousins's paternal grandmother, May, offered it to them at half the standard rent. On weekends, they stayed with Poppy and Trenham at Palm Beach so Cousins could combine studying for the second part of the anaesthesia fellowship exam[24] with walking, sprinting and bodysurfing. He revelled in feeling the salty summer breeze on his face.

The pair had little time for parties and entertaining because Cousins was so busy working and studying. Instead, Michele encouraged him to study in bed, and she snuggled up next to him, reading novels. During the engagement party at her childhood home, one of Poppy's friends had taken Michele aside. 'You're going to marry a doc?' she remarked. 'Well, you'd better be prepared for keeping meals heated up on the stove for hours.'[25] This remark had not deterred Michele, who expected to make sacrifices to support her husband's medical career. 'I knew what I was signing up for in marrying a doctor', she quipped.[26] Like her mother and most

[24] Cousins won the T. Cecil Gray Prize for achieving the highest marks in the anaesthesia fellowship exam. Michael Cousins (hereafter MJC), 'Michael Cousins, Curriculum Vitae', 1990, Cousins, Michael, Medical Biographies Collection, Royal North Shore Hospital Archive (hereafter Cousins, Medical Biographies Collection).

[25] Louisa Jones, interview by GKD, 7 February 2023.

[26] Michele Cousins, interview by GKD, 22 May 2020.

women of her generation, she planned to be an excellent homemaker who devoted herself to supporting her husband's career and raising their children. Of course, in those heady, romantic days, she did not sense the extent of the sacrifices her partner would ask her to make.

In early 1968, Professor Gordon Robson, an eminent Scottish anaesthetist who worked at McGill University in Montreal, toured Australia as the Sir Arthur Sims Commonwealth Visiting Professor. Cousins was eager to meet Robson. 'It struck me he would know Philip Bromage and so might be able to help me obtain a fellowship to work in Montreal', he later wrote.[27]

On 27 March 1968, in a brightly lit meeting room at RNSH, Robson captivated a lunchtime audience of twenty doctors and nurses with a presentation about the neurophysiologic effects of anaesthetic drugs such as halothane.[28] The audience members ate ham, cheese and tomato sandwiches and sipped lukewarm cups of tea. Telephones rang in the background, and ceiling fans whirred overhead.

Cousins was one of the doctors in the room. He had arrived late because the last operation of the morning took longer than expected. Still dressed in his 'surgical greens', he worried he had missed Robson's opening remarks. As he sat on an empty chair in the front row, he opened his notebook to a clean page and tuned in to what the professor was saying. While Robson explained his halothane study, Cousins sat transfixed. Unlike the others, he feverishly scribbled notes on a writing pad. His untouched sandwich sat on a plate on the chair beside him.

At the end of the lecture, Cousins jumped up before the applause ended. He introduced himself to Robson, and they chatted about the professor's research. Cousins asked him whether he collaborated with Philip Bromage.

'Would you like to spend time with Professor Bromage?' Robson said with an amused look on his face.

Surprised, Cousins nodded. 'What do I need to do to work at McGill?'

'Leave it with me', Robson said, before turning to speak with one of Cousins's colleagues.

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[27] Davenport, *Anaesthesia at McGill*, 66.

[28] *Annual Report of the Royal North Shore Hospital*, no. 79, 1968, RNSH Archive.

Months passed. Then, later in 1968, Cousins found a letter in his pigeonhole at the hospital. The envelope was pillar-box red.

I wonder who it's from? he thought as he sliced it open with a pen. It had a Canadian postmark.

'It's a letter from Gordon Robson!' he remembers gasping.

'It's all fixed', he read. 'I've spoken to Philip Bromage. He'd love to have you at McGill, so go to it.' Cousins was impatient to get home to tell Michele but he had a busy afternoon in the operating theatre to complete first.

One week later, he received a letter from Bromage. In 1996, in *Anaesthesia at McGill*, Cousins wrote: 'To this day, I still have the piece of Royal Victoria Hospital stationary with Philip's signature on the bottom as Anaesthetist-in-Chief, informing me of my acceptance as a clinical and research fellow for 1969.'[29] Disappointingly, Bromage's letter no longer exists to enable corroboration of this assertion, which is crucial because Cousins's memory of the job title contradicts Bromage's perception of the breadth of the role. In 1973, Bromage claimed that the position was 'strictly clinical, without provision for academic time and without research space and equipment'.[30]

That night after dinner Cousins stayed up late writing a letter to the University of Sydney's postgraduate medical foundation requesting a fellowship to study at McGill, fondly known as 'Harvard of the North'.[31] 'In order to scrape together the airfare to Montreal', he wrote in *Anaesthesia at McGill*, 'I assembled a rather ragged protocol which aimed to evaluate the effects of epidural analgesia on postoperative pain and vascular graft blood flow following arterial reconstruction'.[32] Disappointingly, after exhaustive searches, this letter was not present in the medical foundation's archives.

Early the next morning, Cousins dropped his application into a red mailbox then hurried to a meeting with the hospital's senior managers. A few months earlier, his colleagues had elected him to chair the 'House Committee', a group of staff who lobbied the hospital's administrators to improve working conditions. The committee had assembled a long list of urgent issues for

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[29] Davenport, *Anaesthesia at McGill*, 66.

[30] Phillip Bromage to F. R. Magarey, 9 July 1973, Cousins, Medical Biographies Collection.

[31] Davenport, *Anaesthesia at McGill*, 28.

[32] Davenport, *Anaesthesia at McGill*, 66.

Cousins to raise at his first meeting.[33] This experience was a vital step in honing the 'legendary' negotiating skills that saw him 'gently guide administrators into decisions they hadn't realised they needed to make'.[34]

At RNSH, Cousins impressed his colleagues with his eloquence and drive, and he was popular. In the Resident Medical Officers' Association *Annals of 1966*, he was described as 'the tanned extrovert', someone who 'projects a sporting image' and is 'willing, able, cheerful'.[35] The following year, Cousins's colleagues wrote: 'Dark and handsome, suave and erudite, sophisticated and yet having the common touch. These are the characteristics of the ideal anaesthetist, and surprisingly here is a man with 'em all. Mike has made many contributions to the wellbeing of his fellows.'[36] In 1968, his profile described him as photogenic and having 'a rich suntan, sleek black hair and sartorial elegance'.[37]

His father, Hedley, had taught him the 'Five Ps'—'prior preparation prevents piss-poor performance'—so he had learned to prepare for meetings carefully. Hedley had also shared tips on negotiating. So did Cousins's articulate uncle, Justice Norman Jenkyn, a Queen's Counsel and later president of the appellate tribunal of the Church of England in Australia. Still, he felt apprehensive because it was the first time he had lobbied decision-makers since his three-year stint as the University of Sydney's Medical Society representative at medical school.[38]

After finding the right room, he opened the squeaky door, pulled out a standard issue hospital chair from the round table, then sat down. The fluorescent lights flickered, and two middle-aged men dressed in dark suits sat chatting. Cousins introduced himself:

> As you know, I'm the staff rep. Last month the House Committee ran a staff survey, and it uncovered several issues. Many of these concerns have been going on for years. One is the poor quality of the hospital's food, about which the former committee chair briefed you, and another is the lack of staff toilets.

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[33] William Doe, ed., *Annals of 1966* (Sydney: RNSH Resident Medical Officers' Association, 1966), 35.

[34] Marc Russo, interview by GKD, 17 January 2021.

[35] Doe, *Annals of 1966,* 27.

[36] Stephen Leeder, ed., *Annals of 1967* (Sydney: RNSH Resident Medical Officers' Association, 1967), 36.

[37] M. J. Sulway, ed., *Annals of 1968* (Sydney: RNSH Resident Medical Officers' Association, 1968), 33.

[38] Blaket, *Senior Year Book*, 119.

The three men explored ways of fixing the problems. After two hours of negotiating, they agreed on a plan to improve the hospital's food and build more staff bathrooms. After glancing at his watch, the young registrar realised he was due in the operating theatre. Excusing himself, he sprinted to the rickety old lift with its polished wooden doors (which still functions today, though the dark lacquer has faded). While waiting for the lift, he reflected on the meeting. Pleased with the outcome, he realised he had enjoyed the 'cut and thrust' of bargaining with the senior managers. Revelling in the opportunity to resolve systemic issues, he hoped he would one day use his advocacy skills to improve the treatment of pain.

In December 1968, he arrived home to discover a letter from the University of Sydney waiting for him in the letterbox. Ripping it open, he tried to read it while unlocking the front door. In the same moment, Michele arrived home. 'We're going to Montreal', he spluttered, grinning from ear to ear.[39] 'Sydney Uni has awarded me a travel grant for a year.[xiv] I can do my pain research with Philip Bromage!'

Though his epic journey had begun, bureaucratic roadblocks forced him to endure an anxious seven-month wait for a visa to work in Canada.

[39] Michele Cousins, interview by GKD, 12 February 2019.

Chapter Two: Montreal

In July 1969, on Cousins's first day at McGill University, he felt euphoric. McGill's Department of Anaesthesia was an international hub for the study of epidural anaesthesia, and Cousins was to spend the next twelve months there as a clinical fellow in anaesthesia. As he approached the enormous wooden doors of the imposing Royal Victoria Hospital, McGill's teaching hospital, he recalled shivering with excitement. The 'Royal Vic' was an austere Gothic edifice perched on top of a steep hill overlooking the Saint Lawrence River (Figures 5 and 6).

Figure 5: Royal Victoria Hospital, Montreal.

Courtesy Daniel Chartrand.

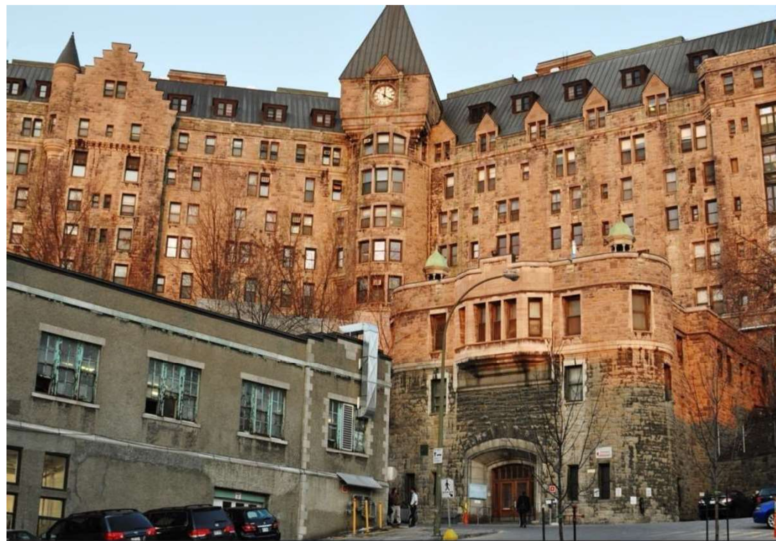

Figure 6: Royal Victoria Hospital, Montreal.

Courtesy Daniel Chartrand.

Once inside the hospital's marble foyer, the anaesthetist Mike Burfoot warmly welcomed Cousins. 'I'll introduce you to Professor Bromage first because I know how eager you are to meet him', Burfoot said. 'After all, it's the reason you've travelled here from the other side of the world.'

Philip Raikes Bromage was close to finishing a world-first study testing how well an epidural anaesthetic reduced a patient's pain after an operation and improved other essential activities such as coughing. He had previously pioneered the use of epidural pain relief for women during labour.[1] Though Cousins had given several epidurals at RNSH, he had never treated women in the labour ward, so he was looking forward to learning this specialised technique. He was not alone. Anaesthetists from around the world flocked to McGill to learn from Bromage.

Burfoot stopped in front of an open door and knocked. A handsome man in his fifties looked up from his rectangular oak desk and smiled. 'Ah, this must be our visitor from Australia', Bromage said in a polished English accent. Tall and trim, with neatly combed grey hair and wearing a dark grey suit, Bromage strode across the office and shook Cousins's hand warmly.

'Welcome to McGill', he said, then pulled out two chairs from the desk and invited Cousins and Burfoot to sit down. The three men chatted about Bromage's ideas on quickly relieving a patient's pain after surgery to hasten their recovery.

Afterwards, Burfoot escorted Cousins on a tour of the hospital and medical school then showed him the third-floor office he would share with the other anaesthesia fellows. It had an internal interconnecting door to Bromage's secretary; Bromage's office was on the other side of his secretary's desk.[2]

Soon after Cousins arrived at McGill, Bromage recognised his potential as a researcher. His young visitor voluntarily embarked on studies whenever he was not anaesthetising patients at the Royal Vic; according to Bromage, Cousins's remit at McGill was as a clinical rather than research fellow. Nevertheless, 'Michael was at once included in a clinical investigation project', Bromage later wrote in a reference for Cousins. 'Shortly after this, and on his own initiative, he began a collaborative study with the Department of Surgery on limb blood flow,

[1] Phillip Bromage, 'Continuous Lumbar Epidural Analgesia for Obstetrics', *Canadian Medical Association Journal* 85, no. 21 (18 November 1961): 1136–40.

[2] Daniel Chartrand, interview by GKD, 25 May 2023.

working long hours and weekends to complete this research project. All this was done quietly and efficiently and without fuss or special demands.'[3] That study on limb blood flow was a partnership with the surgeon Charlie Wright.

The pair embarked on their project two months after Cousins arrived at McGill. As Cousins walked into the ice-cold operating theatre, he felt elated, yet also strangely nervous, an unfamiliar sensation for him.[i] He recalled quivering as he realised the enormity of what he was doing—starting his first scientific study in the world's top centre for research on epidural anaesthesia (Figures 7 and 8).

Figure 7: Operating theatre at the Royal Victoria Hospital, Montreal.

Courtesy Daniel Chartrand.

Figure 8: Looking down from the students' observation gallery, Royal Victoria Hospital, Montreal.

Courtesy Daniel Chartrand.

After chatting with Wright's first patient, a woman in her sixties with varicose veins in her right leg, Cousins attached a thermometer to her right big toe to check the skin temperature of

[3] Phillip Bromage to F. R. Magarey, 9 July 1973, Cousins, Medical Biographies Collection.

her foot because an increase in temperature would indicate a successful spinal nerve blockade. Then he sedated her. Once the patient was asleep, Wright made a slit in her right calf. He removed the diseased blood vessels, replacing them with healthy tissue to form a graft. Fifteen minutes later, Cousins measured the amount of blood flowing through the graft and shin muscles.

After another fifteen minutes, he injected local anaesthetic into the patient's epidural space, then repeated the same measurements. Surprisingly, the amount of blood flowing through the graft dramatically increased. This result astonished the two researchers, who were curious about its cause. During the following weeks, they repeated the procedure on seven more patients, observing similar reactions.

In late 1969, at the same time as this study was reaching its peak, Michele and her husband's first son, James, was born. Cousins hovered anxiously around Michele's bedside while she was in labour; he was relieved it was Bromage who gave Michele an epidural anaesthetic to ease her pain. So was Michele, though in the 1960s, the dose of local anaesthetic was extremely high, and Michele did not enjoy the side effects—loss of sensation and movement in her legs.[4] Nevertheless, she felt honoured that the father of epidural anaesthesia was her anaesthetist.[5]

Once the nervous new parents took James home, he 'turned their lives upside down' because he suffered from colic and woke constantly. Cousins often spent the 'wee small hours' pacing around the apartment trying to settle his newborn. On call at the hospital two nights each week, he tried to arrive home early every other night so he could help Michele with James.

Michele found it difficult to get used to Montreal's 'arctic conditions' during the winter, especially after growing up in Australia near the beach. It was too cold to take James outside, so she felt trapped inside the family's small apartment on her own all day. It was a challenging time for her as she adjusted to life as a new mother in a foreign country without family and friends around her. Nonetheless, her parents had taught her to make the best of difficult situations, so she 'soldiered on'.[6]

[4] Bromage, 'Continuous Lumbar Epidural Analgesia for Obstetrics'.

[5] Michele Cousins, interview by GKD, 22 May 2020.

[6] Michele Cousins, interview by GKD, 22 May 2020.

Following James's birth, Cousins wrote a scientific paper with Wright describing how blood flow through a vascular surgical graft increased with improved pain relief—a revolutionary concept at the time—and they submitted it to the journal *Surgery, Gynecology and Obstetrics.*[7] It was the first time he had written an article for a medical journal, so he was impatient to hear a response from the editor.

During his year in Montreal, Cousins worked full-time as an anaesthetist at the Royal Vic and offered to work extra nights in the operating theatres so he could use the next day for research on acute postoperative pain. Acute pain is the body's warning system that tissue damage has occurred, and it usually settles once the injured tissues have healed. Most doctors at McGill believed that chronic pain—pain that lasts longer than three months[ii]—was just a prolonged form of acute pain.

Cousins thought chronic pain seemed like 'a very obscure, difficult and unappealing area' and he saw his future role in acute postoperative pain. 'All of that changed', however, when he attended a lecture by Ronald Melzack, a famous McGill psychologist. 'It was quite an extraordinary experience to hear him expound on the Gate Control Theory[8] and how it really changed concepts of pain', he recalled. Melzack described the difference between acute and chronic pain, and explained that feeling anxious or tired could increase a person's chronic pain, a new idea that was contested within conservative medical circles.

Around the same time, Cousins met the British neuroscientist Patrick Wall, who had developed the revolutionary 'Gate Control Theory of Pain' with Melzack. Wall told him that different mechanisms in the nervous system caused acute and chronic pain and that if acute pain was poorly managed, it could transition to chronic pain.[9]

Melzack and Wall had proposed the Gate Control Theory of Pain in 1965, four years before Cousins visited McGill. The two researchers had sketched their original idea on a cocktail napkin in a Boston bar several years earlier.[10] In 1962, they wrote an article, 'On the Nature of

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[7] Michael Cousins and Charles Wright, 'Graft, Muscles and Skin Blood Flow after Epidural Block in Vascular Surgical Procedures', *Surgery, Gynecology and Obstetrics* 133 (1971): 59–65.

[8] MJC, interview by Marcia Meldrum, 19 October 1997, Ms. Coll. no. 127.10, John C. Liebeskind History of Pain Collection, History & Special Collections Division, Louise M. Darling Biomedical Library, University of California, Los Angeles, 2.

[9] Ronald Melzack and Patrick Wall, *The Challenge of Pain* (London: Penguin, 1988), 95.

[10] Benedict Carey, 'Ronald Melzack, Cartographer of Pain, Is Dead at 90', *New York Times,* 12 January 2020, https://www.nytimes.com/2020/01/12/science/ronald-melzack-dead.html.

Cutaneous Sensory Mechanisms', describing their concept, which they published in the prestigious journal *Brain.*[11] Wall claimed that only three people ever read it.[12]

Over the following months, the pair wrote another paper, developing their ideas with each new draft. The journal *Science* published 'Pain Mechanisms: A New Theory' in 1965.[13] Melzack later said some researchers loved it, though most hated it.[14]

Melzack and Wall proposed that something occurred in the spinal cord and at other levels of the nervous system to alter the processing of pain signals. Contrary to other pain researchers, they thought pain signals flowed in two directions through the nervous system—from the injured area of the body up the spinal cord to the brain, then back down the spinal cord to the damaged tissues. This idea contradicted the widely accepted theory of pain proposed by the seventeenth-century philosopher René Descartes. Melzack and Wall believed that one of the weaknesses of Descartes's theory was that it did not explain the cause of phantom limb pain or chronic pain.[15]

The two researchers suggested that 'nerve gates' in the spinal cord controlled the flow of pain signals to the brain. Excitatory chemicals in the nervous system opened the gates, increasing the intensity of the pain, and inhibitory chemicals closed the gates, turning down the volume of pain. If a person felt stressed or anxious, the two researchers thought, the nervous system released excitatory chemicals, opening the gates and intensifying the pain. However, if a person was calm and relaxed, the nervous system released inhibitory chemicals, closing the gates and reducing the pain.

If correct, the Gate Control Theory suggested several alternative treatment approaches for chronic pain because it considered psychological factors, such as depression and anxiety, that could alter the way the nervous system processed pain signals. Most doctors dismissed mental

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[11] Ronald Melzack and Patrick Wall, 'On the Nature of Cutaneous Sensory Mechanisms', *Brain* 85, no. 2 (1962): 331–56.

[12] Carey, 'Ronald Melzack, Cartographer of Pain, Is Dead at 90'.

[13] Ronald Melzack and Patrick Wall, 'Pain Mechanisms: A New Theory', *Science* 150, no. 3699 (1965): 971–79.

[14] Melzack, 'Pain: Past, Present and Future', 616.

[15] Ronald Melzack, 'Pain: Past, Present and Future', 615.

health issues linked with chronic pain, classifying them as 'reactions to pain'. They routinely labelled patients with persistent back pain as 'crocks' before sending them to a psychiatrist.[16]

One afternoon at McGill, Wall presented a lecture on the Gate Control Theory to a group of neuroscientists and doctors in room M3.01, the John Symonds Lyon Browne Amphitheatre on Level 1 of the Royal Vic.[17] The 250-seat auditorium was stiflingly hot and overcrowded, with audience members crammed in the aisles and standing at the back behind the seats. Cousins sat spellbound as Wall, who was tall and skinny, bald on top of his head, and wore a beard and largish square glasses, meticulously described existing concepts of pain, then 'tore them apart'. The room erupted as Wall's colleagues reacted to his provocative claims that pain signals flowed in two directions and could be altered in the spinal cord and brain.

As a profession, pain medicine was in its infancy, lacking the resources needed to make breakthrough discoveries about new treatments. After listening to Wall's lecture, however, Cousins sensed pain would one day be a mainstream field of medicine. Acknowledging that it was not a 'sexy' area of medicine—indeed, a few decades earlier it had been considered a 'taboo subject' in surgical texts[18]—Wall nevertheless opened Cousins's eyes to the fast-approaching explosion in knowledge about pain and its treatment. His mind racing with possibilities, Cousins started thinking about research questions he had not thought of before. If he pursued a career in pain medicine, he thought, he would enter the field at its dawn, enabling him to play an influential role as one of its pioneers. For a young anaesthetist in a hurry to make his mark, it was an unprecedented opportunity.

Shortly after the lecture, Cousins found Wall standing in an empty corner of one of Royal Vic's recovery rooms with Melzack, Bromage and a patient who suffered from nerve pain. The researchers seemed more 'fired up' than usual and were experimenting with a primitive-looking machine, a device the size of a doughnut that vibrated—an early version of the

[16] Melzack, 'Pain: Past, Present and Future', 620.

[17] John Symonds Lyon Browne Fonds, 'Complete Inventory List', 158, Osler Library Archive Collections.

[18] René Kieny, 'René Leriche and His Work as Time Goes By', *Annals of Vascular Surgery* 4, no. 2 (1990): 167.

transcutaneous electrical nerve stimulation device that Wall later co-invented, and remains in use today.[19]

'What's going on here today?' Cousins asked, puzzled by the air of conspiracy in the room.

'This device might activate nerve fibres in the spinal cord that curb the flow of pain signals', Melzack grinned.

That day was the beginning of Melzack and Wall's attempts to test the Gate Control Theory.

'It all unfolded from there', Cousins recalled. 'They were trying to see if their theory worked. Once they'd confirmed its practical value, they wanted to create new treatments to improve chronic pain management. So did I.'

Melzack and Wall's original ideas inspired Cousins. The pair described themselves as iconoclasts. Intensely excited by research, they 'lived and breathed it'. 'Research is exciting', Melzack often remarked. 'Enthusiasm energises research. Be enthusiastic about your own and others' research, particularly that of younger people.'[20] These comments resonated with Cousins, whose boundless enthusiasm for research became legendary. He enjoyed meeting people with a similar passion for medical science and he found it electrifying to spend time with his two senior colleagues. Though Wall could be intimidating at times, Cousins admired him: 'Pat had a fierce intelligence, and his mind was razor sharp.' In contrast, Melzack, a Canadian, was gentle with everyone and he 'had a special touch', according to Cousins. 'He was extremely sensitive and very aware of everyone around him.'

Nine months after arriving in Montreal, Cousins received a message from Bromage: Louis Raines, the editor-in-chief of medical books at the publishing house J. B. Lippincott & Co., wanted to meet him. Raines had heard about the young Australian pain researcher and had travelled from Brooklyn to meet him.

Raines asked Cousins to edit a textbook on local and regional anaesthesia, with an emphasis on pain. He explained that Cousins would need to travel the world talking to pioneering pain

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[19] Transcutaneous electrical nerve stimulation involves the application of electrical impulses to the nerve endings to relieve pain. Ronald Melzack and Patrick Wall, 'Acupuncture and Transcutaneous Electrical Nerve Stimulation', *Acupuncture in Medicine* 3, no. 1 (April 1986): 3–23.

[20] MJC, 'History of Pain Management: Developments in Australia and Beyond', April 2009, MJC Private Collection.

researchers about their findings. Cousins felt flattered and eagerly accepted the offer despite its daunting nature. He and Raines discussed possible co-editors. They needed someone from North America who was better known, because Cousins, as a young Australian pain researcher, did not yet have a high profile; Raines believed appointing a respected co-editor would help to attract talented contributors.

Cousins had planned to return to Australia after one year in Montreal. A few months after arriving, however, he had received a phone call from John Bunker, chair of Stanford University's Department of Anesthesiology. Bunker had heard about his epidural analgesia research and offered him a one-year role at Stanford as an assistant professor and staff specialist anaesthetist in the university's teaching hospitals. Michele was excited about the opportunity, though she felt disappointed about changing the original plan to return to Australia after twelve months in Canada. Although eager to return to Sydney to spend time with her family and friends, she agreed to move to Stanford for one year because she knew it was a tremendous opportunity for her husband to consolidate his interest in academic medicine.[21]

In July 1970, the family left Montreal for the month-long drive to Stanford. The brand new Mercedes they had shipped from Germany lacked air-conditioning, and they travelled the 5,000 kilometres from Montreal to California through blazing heat with 'a baby bouncing around in the back of the car'.

Whenever Michele drove, Cousins took the opportunity to reflect on his experiences at McGill. He had appreciated the opportunity to learn Bromage's 'meticulous approach' of taking detailed notes on each patient for research purposes. 'It was a great example that has stayed with me to this day', he later wrote.[22] His most important learning, though, was experiencing firsthand the integration of clinical care, teaching and a 'vigorous research program'. It would be the blueprint for the pain centres he later established in Australia. Marvelling at the high morale and mutual regard among the staff in McGill's anaesthesia department, he later admitted: 'Over the years I have come to realise how difficult it is to engender such a wonderful team spirit in the current health climate.'[23]

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[21] Michele Cousins, interview by GKD, 1 May 2019.

[22] Davenport, *Anaesthesia at McGill*, 67.

[23] Davenport, *Anaesthesia at McGill*, 68.

A few days before the family embarked on their journey, Cousins learned that the journal *Surgery, Obstetrics, Gynecology* had prepared the proofs for his research paper with Wright on the effects of epidural analgesia on pain and blood flow after blood vessel surgery.[24] Wright had promised to send the proofs to a post office box in Calgary, so when the manuscript arrived in that city, Cousins picked it up. He said he had goosebumps while he sat in the car reading it and regretted leaving his good friend Charlie. Though the pair had struck up a 'tremendously strong research partnership', he believed his next destination—Stanford University—'was an absolute powerhouse, as it still is'.

[24] Cousins and Wright, 'Graft, Muscles and Skin Blood Flow'.

Chapter Three: Stanford

The family arrived at Stanford University in late August 1970 and despite the 5,000-kilometre drive, they felt exhilarated. Cousins was impatient to start his new role, and before finding their modern home on the edge of Mountain View, they drove around the campus, captivated by its beauty.

His first day as a staff anaesthetist at Stanford Medical Center and the Veterans' Administration Hospital in Palo Alto was 1 September 1970. That morning and every day thereafter, he rode his bicycle nine kilometres to either of the hospitals, relishing the opportunity to keep fit and ponder his research ideas. His position involved clinical duties three days each week, with the other two days at Stanford University continuing his research about the effects of epidural anaesthesia on postoperative pain.

While in Montreal, he had often chatted with a McGill vascular surgeon, John Gutelius, about the toxicity of drugs commonly used as general anaesthetics. One of these conversations was about kidney physiology and how anaesthetic drugs affected it. Keen to learn more, he studied journal articles on the topic. Gutelius had told him that a Stanford anaesthetist, Richard Mazze, was studying the toxicity of the general anaesthetic methoxyflurane, and suggested they meet.

Once Cousins's roster at the hospital stabilised, he met with Mazze. The first thing he noticed was his colleague's intense intellectual energy. Their conversation about methoxyflurane toxicity energised Cousins, making him impatient to embark on his own research. A few weeks later, he recalled, he was sitting in his office at Stanford University 'fossicking around in his bottom desk drawer' when Mazze walked across to him.

'Would you like to join me on my methoxyflurane studies?' Mazze asked.

Though Cousins was tempted, he was determined to continue his own studies on the effects of epidural anaesthesia on pain and blood flow. During the next few weeks, Mazze urged him to reconsider his offer. Cousins was conflicted; in the end, Mazze was so persistent that Cousins delayed the start of his epidural research and instead embarked on several studies with Mazze on methoxyflurane toxicity.

During the following weeks, the two researchers planned their project. Eager to know whether methoxyflurane was toxic to the kidney and, if so, why, they spent long hours in the laboratory studying the effects of methoxyflurane on rats. This was a strange experience for Cousins because he had not previously worked with small laboratory animals. Nevertheless, he appreciated the opportunity to learn a new skill.

To give himself extra time for research, he spent a full day in the hospital's operating theatres anaesthetising patients and then worked a night shift, which freed him the next day to focus on experimental studies.[i] This regimen was taxing, particularly when he studied the effects of methoxyflurane on patients because it meant arriving at the hospital at five o'clock in the morning—even though he was not a 'morning person'—to get everything ready.

One day in 1971, Cousins remembered sitting next to Mazze in the brightly lit laboratory reviewing the results of a study. Suddenly, the pair looked across at each other.

'This data shows methoxyflurane is toxic to the kidney at the doses anaesthetists use during surgery', Mazze said.

Cousins nodded. 'It looks like the liver breaks it down into by-products that do the damage.'

They conducted several more studies and once they were certain their findings were correct, they set out to ensure the American Government banned methoxyflurane from operating theatres. First, they met with representatives from the Food and Drug Administration, hoping the agency would ban methoxyflurane. However, the agency's managers refused to act. To Cousins's surprise, the following year, the agency appointed him as a consultant to advise on methoxyflurane toxicity.[ii]

Cousins and Mazze discussed their conclusions with the American Medical Association and pharmaceutical industry leaders. Some executives at these meetings were openly hostile, criticising their results. Undeterred, the pair continued their campaign, using every opportunity to lobby decision-makers. Cousins recalled that several influential individuals and organisations fiercely contested their findings; however, he and Mazze persevered.

Hedley Cousins had taught his son to demonstrate leadership and resilience under challenging circumstances, so when Cousins's confidence flagged during the methoxyflurane struggle, he drew strength and reassurance from how Hedley had always fought for what he believed was

right. Despite the controversy, he enjoyed studying methoxyflurane toxicity and appreciated learning rigorous scientific methods. It also kindled his interest in pharmacology as a broad subject, as well as toxicity, because: 'No drug is useful unless it has a sufficient margin between safe and toxic doses.'

The Stanford years were a busy time for the family, especially after Michele started a part-time role editing medical research papers. She loved her job, and they enjoyed living in California. On weekends, the couple explored national parks or shared lunches and dinners with colleagues from the hospital and university, forming lifelong friendships.[1]

One year after arriving at Stanford, Cousins flew to Seattle to meet John J. Bonica, the 'founding father of pain medicine',[2] to seek his advice on the epidural analgesia and blood flow study. Bonica had been driven to improve pain management because he, too, lived with severe lower back pain.[iii] Following World War II, he had cared for injured soldiers returning from the front with severe pain. The war veterans' pain problems were so complex that Bonica quickly realised his skills as an anaesthetist were inadequate to treat them. Instead, he thought the veterans required help from a team of doctors from different fields.

In 1947, Bonica set up a pain centre in Washington State staffed by clinicians from various medical specialties.[3] Later, he launched a pain clinic at the University of Washington (UW) in Seattle. Every Friday at noon, a team of specialist physicians from the UW Medical Center met to discuss the patients with chronic pain they had seen during the previous four days. The week Cousins visited UW, he took part in a Friday meeting. Shortly before midday, doctors streamed into a large meeting room and sat around a long rectangular table. The energy level was high as they chatted, their pagers beeping incessantly.

When Bonica strode in at precisely twelve o'clock, a hush fell over the room. One by one, doctors spoke about the patients they had assessed that week. Perched on the edge of his seat, Cousins was astonished to hear anaesthetists, rehabilitation specialists, neurologists, psychiatrists and rheumatologists all discuss the same patients. This approach was an early version of multidisciplinary (and, later, interdisciplinary) pain management—a combination of

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[1] Michele Cousins, interview by GKD, 21 May 2019.

[2] John Liebeskind and Marcia Meldrum, 'John J. Bonica, World Champion of Pain', *Progress in Pain Research and Management* 8 (1997): 19.

[3] John Loeser, 'In Memoriam: John J. Bonica', *Pain* 59, no. 1 (24 August 1994): 1–3.

specialist medical, psychological, physiotherapy and other professional services to address the multiplicity of issues faced by people living with chronic pain.[iv] It was the first time he had witnessed a team approach to managing chronic pain, sparking his interest in practising multidisciplinary pain management.

Colleagues at McGill and Stanford had warned Cousins that Sicilian-born Bonica, the formidable 'Grand Man' of pain medicine, had a dominant character and was a 'force to reckon with'. Cousins was apprehensive about his first one-on-one meeting with the professor, scheduled for later in the afternoon. 'I was afraid I'd say something stupid', he later admitted, 'or that John Bonica would think I was wasting his time'.

All too soon, it was four o'clock. Bonica's latest secretary—he cycled through assistants incredibly quickly[v]—buzzed him to let him know that Cousins had arrived for their meeting.

'Well, just have him come in', Bonica called out.

When Cousins stepped inside Bonica's spacious office, the first things he noticed were an imposing mahogany bookcase overflowing with bulky tomes and an antique globe of the world, which he soon learned served as a liquor cabinet. Two soft couches were positioned along one wall directly opposite the desk, which rested on something that looked like a pedestal—a 'riser' to increase Bonica's height in relation to guests when he sat at his desk.[vi]

Bonica, who wore his 'characteristic uniform'—a three-piece suit with gold watch chains suspended from the waistcoat and gold-rimmed glasses—rose to greet his visitor. 'John wasn't very tall, but he had massive hands and a steel grip', Cousins recalled. 'I felt my bones would break if he'd squeezed my hand any harder.' The older doctor's stocky build astonished Cousins. 'His broad shoulders were almost as wide as his height, and his enormous chest looked as hard as a rock.'

During the meeting, Bonica 'listened with apparent irritation' to Cousins's description of the blood flow study, 'firing off a series of staccato questions'. As someone who craved Bonica's approval, this response was disconcerting. At the end of the meeting, Bonica's remark indelibly imprinted itself in Cousins's memory: 'Not bad, son. Keep up the excellent work.' As Cousins stood up to leave, Bonica's parting words encouraged him. 'Always get your facts right, son. And never, never give up. Persevere, persevere, persevere.' Perhaps fifty-four-year-old Bonica saw in his visitor an earnest, youthful version of himself? That encounter would be the genesis

of a two-decades long relationship that would see Bonica mentor Cousins, profoundly shaping the field of pain medicine in Australia.

After returning to Stanford, Cousins posted Bonica a pristine copy of his article in *Surgery, Obstetrics, Gynecology* to replace the rough manuscript copy he had left with the professor.[4] Two weeks later, when he read a congratulatory letter from Bonica, he was elated. 'The study was well-done and the information important', Bonica wrote. 'Please accept my best wishes for your continuing success.'[5]

In early 1972, Michele gave birth to the couple's second son, Richard. Much to his parents' relief, Richard quickly fell into a routine. An 'angelic' baby, he breastfed well, slept soundly and was always happy. Of course, no-one imagined what the future would hold for him.

During the late 1960s and early 1970s, an informal movement of doctors, allied health professionals and scientists who were interested in pain medicine formed around Bonica. He longed to encourage 'basic researchers' (who conducted experiments in a controlled laboratory setting with non-human subjects) to team up with 'clinical researchers' (whose research involved patients). These collaborations, he believed, would hasten the development of new pain treatments, which, until then, had proceeded at a glacial pace.

Bonica waited until the pain medicine community had 'built up a head of steam', then, in late May 1973, he invited pain professionals from around the world to an International Symposium of Pain in a former convent in Issaquah, outside Seattle. This, the first comprehensive, international, multidisciplinary conference about pain and its management, marked the 'birth of the field of pain study'.[6]

To Bonica's surprise, 350 delegates from thirteen countries flocked to Issaquah and they unanimously agreed to set up an international organisation devoted to pain research and treatment, naming it the International Association for the Study of Pain (IASP). IASP members later elected a leadership team they named the IASP Council.[vii] It included representatives from fifteen countries who would play a pivotal role in Cousins's career. To his immense

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[4] MJC to John J. Bonica (hereafter JJB), 24 August 1971, Box 2, Folder 29, Bonica Papers (John J.) Collection 118, Louise M. Darling Biomedical Library History and Special Collections for the Sciences, University of California, Los Angeles (hereafter Bonica Papers).

[5] JJB to MJC, 9 September 1971, Box 2, Folder 29, Bonica Papers.

[6] Liebeskind and Meldrum, 'John J. Bonica, World Champion of Pain', 19.

disappointment, Cousins was on duty at Stanford Medical Center during the Issaquah conference and could not attend. After several colleagues told him the mood at the event was electrifying, he resolved to contribute to its development,[7] though no-one could have predicted the significance of his involvement and its influence on the field of pain medicine.

From the start, Louisa Jones, the editor of several research publications in Bonica's department, was the 'powerhouse' who meticulously drove every aspect of IASP's operations. She later became IASP's executive officer. Fortunately, she saved every letter Bonica wrote and received, the minutes of IASP meetings and countless other documents that are now housed in the John C. Liebeskind History of Pain Collection at the University of California, Los Angeles. Disappointingly, no-one thought to save telexes, telegrams, aerograms and faxes. Within the Bonica Papers (John J.) is a bulky folder of letters between Cousins and Bonica that chronicle turning points and transformative moments in their professional and private lives.[8]

Cousins's superiors and colleagues recalled that he quickly stood out as notable during his time at Stanford because of his determination to understand the science of pain. He did everything in his power to relieve his patients' pain. The neurosurgeon and pain medicine pioneer John Loeser recalled that he kept hearing about a young Australian doctor who was impressing his Stanford colleagues. According to Loeser, Cousins was considered a rising star because he was a talented researcher, a skilled and empathetic clinician, and a promising leader. 'He was on everyone's shortlist because he was hardworking, easy to get along with and going up in the world', Loeser remarked in an interview fifty years later.[9]

Cousins's workload intensified after Bunker appointed him as director of the pain centre at the Veterans' Hospital; this was in addition to his roles as hospital anaesthetist, researcher[viii] and co-editor of the regional anaesthesia textbook. Bonica had shared a tip with Cousins for tackling a demanding schedule: 'You don't have to end the day after dinner. Enjoy a little snooze after reading your kids a bedtime story and tucking them into bed. Then after the nap, write late into the night.' From then on, Cousins followed this advice. Writing until midnight became a habit he would continue for the next five decades, even on weekends and during holidays.

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[7] Davenport, *Anaesthesia at McGill*, 68–69.

[8] MJC and JJB, Correspondence, Box 2, Folder 29, Bonica Papers.

[9] J. Loeser, interview by GKD, 28 September 2019.

During 1973, Philip Larson, a McGill-educated anaesthesiologist and head of Stanford's anaesthesia department after Bunker resigned, invited Cousins to extend his appointment at the university. However, Michele, despite enjoying California's lifestyle and her job as a medical editor, was eager to return to Australia to be with her family and friends.[10] The couple discussed the opportunity late into every night for a week. Deeply conflicted, Cousins felt privileged to have learned from the pain world's leaders, and he was eager to consolidate his learnings at Stanford. Yet he also wanted to 'repay' the University of Sydney for its travel fellowship by returning to practise pain medicine in Australia. Remaining at Stanford was tempting because, as director of the veterans' pain unit, he treated patients who lived with chronic pain. He was also conducting studies on acute pain after surgery. The balance was overwhelmingly in favour of staying at Stanford because opportunities for academic research in anaesthesia were 'virtually nil' in Australia.

Nonetheless, they felt the powerful tug of home. 'A little bell rings in the breasts of Australians when they are away from their motherland', Cousins stated. 'Eventually, it becomes too strong to ignore.' In the end, they decided to return to Australia so they could spend time with their ageing parents. They also wanted their children to grow up in Australia, close to their grandparents and cousins.

After launching his research career in North America, Cousins was eager to pursue it in Australia. His goal was to secure a role that would enable him to combine clinical practice, research and teaching.[ix] In mid-1973, he applied for a senior management role as director of the Kolling Institute of Medical Research—the oldest medical research institute in New South Wales—and a few months later, for a staff specialist anaesthetist position at RNSH.[11]

Within a few weeks of applying for these roles, he mobilised over a dozen pain medicine pioneers and distinguished colleagues, including Bonica, Bromage and Bunker, to write letters of support for his applications,[x] an early indication of his ability to garner the support of acclaimed individuals within his network who could advance his goals. His referees all affirmed his extraordinary enthusiasm and excellent skills as a clinician, researcher and teacher.

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[10] Michele Cousins, interview by GKD, 19 October 2019.

[11] MJC, 'Staff Specialist Anaesthetist: Application for Staff Appointment', 28 November 1973, Cousins, Medical Biographies Collection.

They also attested to his innovative and original ideas for research, immense work ethic, and popularity and trustworthiness as both a colleague and friend.[xi]

Before departing for Sydney, Cousins spent a week at the Virginia Mason Medical Center in Seattle with Daniel Moore, director of anaesthetics. While there, he chatted with Philip Bridenbaugh, a distinguished regional anaesthesia researcher. During the visit, he asked Bridenbaugh to partner with him on co-editing the regional anaesthesia textbook. Bridenbaugh enthusiastically accepted the invitation, and so began a productive multi-decade partnership.[xii]

At Stanford, Cousins learned the immense value added to patient care by integrating treatment and scientific research. Interacting with the giants of pain medicine reinforced his drive to pursue excellence and learn from the very best—two of his lifelong traits. Discovering several distinguished role models to guide him, he took every opportunity to learn from them. The standards Melzack, Wall and Bonica set naturally came to be the standards he embraced. Cousins particularly internalised Bonica's values, priorities and modus operandi and was determined to replicate them on his return to Australia. Clearly, he did not realise the Herculean efforts this would require. Or perhaps he did?

Chapter Four: The Tug of Home

In December 1973, two months after Queen Elizabeth II opened the Sydney Opera House, Cousins, Michele and their sons flew into Sydney's Mascot Airport at dawn. Initially, the family stayed with Michele's parents at their holiday house at Palm Beach. However, within a few weeks, Cousins and Michele bought a house they both liked in Pymble, one suburb away from both sets of grandparents and their childhood homes.

Although elated to be 'home', Cousins encountered 'a not terribly receptive environment'[1] on the career front: both his job applications were unsuccessful. At that time, most Australian doctors specialised in England and those who studied in America were viewed as 'cowboys' on their return to Australia. Many of them languished as outsiders in Sydney's tight-knit medical circles, forcing them to search elsewhere for career opportunities,[2] as would be Cousins's ultimate fate.

Two months after his return, RNSH appointed him as an assistant staff anaesthetist, a lowly position compared to the one he had held at Stanford. Though it rankled him that the hospital failed to recognise his achievements at McGill and Stanford, it did not deter him from pursuing his ambitious agenda. Within three weeks of his appointment, he wrote to Roger Vanderfield, the hospital's medical superintendent, signalling his intention to continue his Stanford research, though this was not within the scope of his job description.[i]

Reminding Vanderfield of his interest in pain medicine, he requested permission to accept a part-time appointment as a visiting consultant at Lidcombe Hospital—during RNSH working hours—to treat elderly patients living with chronic pain.[3] This audaciousness so soon after starting a new job, and a junior one at that, reflected his impatience to advance his career. It was also an early indication of his tendency to 'dig in and fight' when roadblocks obstructed the pursuit of his vision.

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[1] MJC, interview by Marcia Meldrum, 13.

[2] Boyle, interview; Reeve, interview.

[3] MJC to Roger Vanderfield (hereafter RV), 6 March 1974, Cousins, Medical Biographies Collection.

Six months after returning to Australia, he successfully applied for a clinical position at RNSH as a staff specialist anaesthetist.[4] An undated article in *Synapse*, the staff newsletter, stated that the University of Sydney had also appointed him as a research affiliate and that his duties would include 'the practice and teaching of anaesthesia and intensive care, also clinical pharmacology and research'.[5] Clearly, his vigorous campaign to combine clinical responsibilities with research and teaching was successful, though the article did not mention his principal interest and goal: pain management.[ii]

Subsequently, Cousins lobbied for funding to continue the toxicity research that he and Richard Mazze had conducted at Stanford. 'Michael's battle for resources was the norm', Tom Reeve explained. 'You fight all the time for money, space and facilities.' Reeve noticed that Cousins's research activities alienated several colleagues because it reduced the time he was available to provide anaesthesia to patients undergoing surgery, increasing the workload of other anaesthetists.[iii] Reeve 'watched from the sidelines'; according to him, despite 'pushing the boundaries', Cousins was always diplomatic.[6]

Shortly after starting his new role, Cousins requested 'special leave' for three weeks and funding from RNSH to travel to Stanford as a visiting professor. In a typed letter, he told Vanderfield that the American Society of Anaesthetists had invited him to present a lecture.[iv] While in America, he planned to meet several of the thirty-nine contributors to the textbook on neural blockade he was co-editing with Bridenbaugh.[7] It was a risky move for a new employee, and indicative of his future behaviour.

Later, in 1974, Cousins recalled Mazze telephoning him. Mazze said several countries had banned methoxyflurane from their operating theatres.[8] The scientific papers the two researchers had published detailing the relationship between methoxyflurane and kidney toxicity had rocked the anaesthesia world. The pair's courage, doggedness and willingness to fight for something they believed in had borne fruit. While Cousins had found the experience intensely

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[4] MJC, 'Application for Staff Appointment, 19 June 1974', Cousins, Medical Biographies Collection.

[5] Editor, *Synapse,* RNSH staff newsletter, undated, Cousins, Medical Biographies Collection.

[6] Reeve, interview.

[7] MJC to RV, 16 August 1974, Cousins, Medical Biographies Collection.

[8] P. Rohrs, 'Richard Mazze, MD, Researcher, Builder and Leader Extraordinaire', *The Gas Pipeline Anesthesia Quarterly Gazette* (February 2011), http://med.stanford.edu/content/dam/sm/anesthesia/gasPipeline/2012.February.pdf.

stressful, he accepted it was a valuable learning opportunity, one he would often draw on when facing disappointment and failure.

Towards the end of Cousins's first year back in Sydney, Reeve told him that Flinders University (FU) in Adelaide was advertising for a foundation professor of anaesthetics and intensive care—the first chair of its kind in Australia[v]—at Flinders Medical Centre (FMC), the nation's first integrated teaching hospital and medical school.[9] 'The medical school and hospital buildings should be planned and built as an integrated whole', the facility's 'Preliminary Functional and Policy Brief' noted. 'It follows that there will be a close relationship between patient care, teaching and research.'[10]

The role piqued his interest, yet Cousins did not apply for it, believing that at thirty-five years of age, he was too inexperienced to be a full professor. Nonetheless, by this early stage of his career, in partnership with research collaborators such as Bromage, Wright, Mazze and Reeve, he had published thirty-six scientific papers[11] and the University of Sydney had awarded him a doctorate in medicine for the research he and Mazze had conducted on the toxicity of inhaled anaesthetics.[12]

FMC's founding dean and chairman Gustav Fraenkel, an Oxford-educated surgeon and advocate of the so-called 'tripod' of medicine—patient care, teaching and research—encouraged Cousins to apply. Fraenkel was known for his talent of recruiting smart, ambitious young doctors and scientists from Australia and overseas then 'imbuing them with a commitment to his beloved "tripod"'.[13]

Cousins told Reeve that he did not intend to apply for the role; however, the older surgeon urged him to reconsider. 'Flinders was *the* place to go', Reeve recalled. 'It was a place to build something new.' Reeve explained that RNSH anaesthetists focused solely on giving patients anaesthesia in the operating theatre. 'Michael didn't want to be a clinician doing anaesthesia

[9] John Chalmers, 'Surgeon United Clinic and School', *Australian*, 25 September 1998.

[10] Project Planning Office, 'Preliminary Functional and Policy Brief', 20 April 1971, Box 10, Folder 9, Gus Fraenkel Collection, Flinders University (hereafter Fraenkel Collection), 3.

[11] Marc Russo, 'The Michael J. Cousins Lifetime Achievement Award', International Neuromodulation Society Annual Scientific Meeting, Sydney, May 2019, Marc Russo Private Collection.

[12] MJC, 'Anaesthetic Toxicity: Metabolism and Nephrotoxicity of Fluorinated Inhalation Anaesthetics' (PhD thesis, University of Sydney, 1975).

[13] Chalmers, 'Surgeon United Clinic and School'.

all day; he was a young man in a hurry. He'd have to wait too long to reach the level of seniority required to pursue his research interests.' Reeve believed that FMC offered an enormous opportunity for Cousins to develop in his own way. 'Michael had sound expertise and knew what he was doing. I was prepared to back that.' Reeve trusted Fraenkel to appoint smart people who would support Cousins's ambitions.[14] Later, he realised his trust in Fraenkel had been misplaced.

Cousins posted his application and, a few weeks later, on 8 November 1974, he flew to Adelaide for an interview.[15] While there, he looked at an aerial view of the campus, which was set out of town among the hills. 'I remember a shiver ran up my spine', he said, 'because the campus looked similar to that of Stanford'.[16]

After the interview, secure in the promises Fraenkel had made to him if he was the successful candidate, Cousins returned to Sydney. The following week, Fraenkel offered him the position. Though elated, the responsibility and effort required to build an anaesthesia service and pain centre 'from scratch' daunted him. Nevertheless, he resolved to follow Bonica's lead and create a pain centre like the one he had witnessed at the University of Washington. It would be the first of its kind in Australia.[vi] Clearly, he did not fully realise the enormity of the challenges ahead of him.

In mid-January 1975, Cousins informed Vanderfield of his new role and intention to resign at the end of the year. In the letter, he detailed his achievements in establishing pain medicine research and pain management services at the hospital. He also thanked Vanderfield for supporting his anaesthetic toxicity research.[17] A few months earlier, in a lengthy letter to Vanderfield, he had outlined his research successes at RNSH during 1974, flattering the medical superintendent for encouraging and supporting his endeavours.[18]

With the FMC still under construction, Fraenkel wrote to Vanderfield asking him to allow Cousins to travel to Adelaide from 'time to time' to provide advice on facilities and policies.[19]

[14] Reeve, interview.

[15] Gus Fraenkel (hereafter GF), personal diary entry, 8 November 1974, Fraenkel Collection.

[16] MJC, interview by M. Meldrum, 13.

[17] MJC to RV, 17 January 1975, Cousins, Medical Biographies Collection.

[18] MJC to RV, 10 September 1974, Cousins, Medical Biographies Collection.

[19] GF to RV, 21 February 1975, Cousins, Medical Biographies Collection.

Those visits enabled Cousins to influence the design of the operating theatres, ensuring they met the needs of *both* anaesthetists and surgeons. Radiating energy and enthusiasm, he also lobbied for research laboratories and an animal house for laboratory animals such as rats and guinea pigs.

During the period he commuted to Adelaide, Michele gave birth to the couple's third son, Jonathan, at RNSH. After the birth, Cousins worried about Michele's health because she left the hospital suffering from chickenpox, mastitis and shingles. Michele baulked at the idea of moving to Adelaide so soon after returning from America and she felt heartbroken to be leaving her family and friends again. At the same time, she enjoyed being her husband's confidante; he often consulted her on crucial work-related decisions and respected her opinions. She knew he leaned on her to keep his home life running smoothly and to help him advance his career, but she had anticipated this before they married and so willingly accepted it. A committed homemaker whose top priorities were supporting her husband and raising healthy, happy children, she loved her critical role in supporting his quest.[20]

In those days, many Sydneysiders, including Michele, thought of Adelaide as a large country town rather than a city. However, change was afoot, and it would profoundly impact the family.

In 1970, South Australians had elected Don Dunstan's progressive Labor Party to govern the state. Dunstan was intent on reforming social policy.[vii] Within a few years of being elected, his government would radically reform environmental, consumer protection, racial discrimination, women's and Indigenous policy.[21]

The Cousins family arrived in Adelaide in the middle of a heatwave in late 1975. At first, they lived in the un-airconditioned 'Flinders flats'—furnished 'huts' on campus for new nursing and medical staff. Michele's mother Poppy arrived soon after to help her daughter, who was still suffering from shingles. Poppy and Michele started searching for a house: it would take Michele six frustrating months to find one she loved. That home was 'Highfield', a gracious National Trust building that stretched the family's budget.

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[20] Michele Cousins, interview by GKD, 23 August 2019.

[21] 'The 1970s', State Library of South Australia, accessed 15 January 2024, https://www.samemory.sa.gov.au/site/page.cfm?u=360.

Shortly after moving into Highfield, Cousins set up a study in the one carpeted room of the huge basement. ‘Sunshine streamed in from casement windows, making me feel less cut off from the outside world while I was working’, he remarked. ‘It was beautifully quiet, the perfect place to work on weekends, something I sensed I’d be doing quite often if I was to make any headway.’

Chapter Five: A Fledgling

The camaraderie among the medical school's professors impressed Cousins when he arrived at Flinders University (FU). They all 'camped' close together in study cubicles in the library[1] because tradesmen were still fitting out the medical school—an ideal way, he thought, for the new professors to get to know each other and start collaborating on research.

Gus Fraenkel had recruited a team of young, extremely ambitious and, according to several Flinders Medical Centre (FMC) staff, 'manipulative' professors to head each department. At one meeting, an angry department head hissed: 'Over my dead body!' when Cousins outlined his plan to build a pain centre. Decades later he recalled:

> We were all great friends slapping each other on the back when we abutted on each other in the library. But when it came time for the cut and dice, it was every man for himself. I'd seen nothing quite like it. I was new at the game and still learning the ropes. I knew I needed to ramp up my efforts a hundredfold.

Fraenkel's intention was for FMC to provide a full range of medical services, specialising in areas of medicine in which staff had expertise and research interests.[2] In a 2019 interview, Cousins was emphatic that he had made clear to Fraenkel and the interview panel his intention to establish a pain centre modelled on the one he had witnessed at the University of Washington (UW).[3] His resume had also emphasised his pain medicine achievements.[4] By appointing him, he assumed he had a mandate to establish a pain centre as well as an anaesthesia and intensive care service. So did Reeve, who was in regular communication with Fraenkel and Cousins.[5]

Cousins recalled a contentious meeting with the hospital's department heads and senior managers late one Sunday afternoon, a month after he moved to Adelaide. Eight men, each jostling for dominance, sat around a large rectangular table debating funding submissions. It was stiflingly hot and humid. Towards the end of the fractious meeting, when everyone just

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[1] FMC's library opened in February 1975 as part of Phase One of the building.

[2] Crispin Hull, 'University Medical Centre Opens Soon', *Canberra Times*, 11 February 1976, 14.

[3] MJC, interview by GKD, 1 May 2019.

[4] MJC, 'Curriculum Vitae: Dr Michael Cousins', 1974, Cousins, Medical Biographies Collection.

[5] Tom Reeve believed Cousins 'didn't get the deal at Flinders he should've got, once he got there'. Reeve, interview.

wanted to return home and enjoy a cold beer, they reached Cousins's proposal, requesting financial support from the university and hospital to build a multidisciplinary pain centre. One of the more outspoken young professors snarled: 'Cousins, if you think you're going to walk out of this meeting with funding to set up a pain centre, you've got another thing coming.'

The hospital administrator stiffened, glaring at Cousins: 'Your brief is to create an anaesthetic service in the operating theatre and intensive care unit. Pain research and a pain clinic are not part of that brief.' This remark accurately reflected the description of the anaesthesia and intensive care service Fraenkel outlined in the 'Preliminary Functional and Policy Brief' he wrote in 1971. The brief did not mention facilities, funding or personnel for pain management.[6]

It is unclear whether Cousins read this brief or other background documents before accepting the role. As someone who painstakingly weighed up the 'pros and cons' while making decisions, it is inconceivable to think he would have accepted the position if he knew the building plans did not include a pain clinic and that Flinders had not assigned funding to operate it. Surely, he would have asked questions about the anaesthesia department's budget, facilities and staffing?

The mid-1970s were a time of high inflation and economic stress, and the launch of the national, publicly funded health insurance system Medibank[7] created uncertainty about hospital funding.[8] Surely Cousins knew from his struggles to finance research at RNSH that health budgets were under intense pressure and that the likelihood of securing funds to build a pain centre would be low. Until then, his career was as a clinician and researcher. Perhaps his lack of management experience meant that he was too trusting to ask the interview panel about the anaesthesia department's funding model? Yet, several Flinders colleagues asserted that

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[6] Project Planning Office, 'Preliminary Functional and Policy Brief', 13.

[7] Australian Government, 'Medicare: Background Brief', 29 October 2004, https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/Publications_Archive/archive/medicare.

[8] Flinders Medical Centre (FMC), 'A Report of the Flinders Medical Centre April 1976 to 30 June 1979', 3, Box 15, Folder 3, Fraenkel Collection.

Cousins could not be described as naive, insisting he was politically, operationally and financially savvy, even in his mid-thirties.[9]

Equally puzzling questions surround Fraenkel's appointment of Cousins, knowing the young anaesthetist and pain specialist's intentions. Reeve, who knew Fraenkel well because they were both vascular surgeons, claimed that Fraenkel knew 'precisely' what Cousins's pain medicine ambitions for FMC were.[10] Did Fraenkel, whom insiders described as fiercely ambitious and manipulative, mislead Cousins, promising him he could establish a pain centre, while knowing it was unlikely? According to Kathie Knights, a research officer who later worked with Cousins on anaesthesia toxicity studies, colleagues across the hospital told her about Fraenkel's promises to them regarding resources that never eventuated.[11]

Perhaps Fraenkel agreed to build a pain centre during Cousins's interview but was unable to honour this because the state government reneged on its funding promises to the hospital? This is possible, given budget cuts across South Australia's hospital system and the FMC's grim financial situation, which was soon revealed.

In media interviews, Fraenkel stated his intention to attract the most accomplished professionals to Flinders.[12] Cousins's prominence in the field of anaesthesia, combined with his laudatory referee reports from Bonica, Bromage, Melzack, Wall and Bunker, might have convinced Fraenkel that he possessed the ability to achieve the impossible. What is irrefutable is that Fraenkel was cognisant of the formidable battle Cousins would face in achieving his aspirations. Yet did Cousins realise this?

It is possible that Cousins was conscious of the true situation and thought he could follow Bonica's example and solicit resources through vigorous lobbying? He had witnessed the power of advocacy through the successful advertising careers of his father Hedley and brothers Keith and Geoff, so it is a possibility. Bromage had employed him as a full-time clinician at McGill, yet, through sheer determination and a stubborn willingness to sacrifice time with

[9] Kathie Knights, interview by GKD, 28 August 2023; L. Mather, personal communication, 21 September 2023; Geoff Gourlay, interview by GKD, 15 February 2023.

[10] Reeve, interview.

[11] Knights, interview by GKD, 24 October 2023.

[12] Hull, 'University Medical Centre Opens Soon', 14.

Michele and James, he conducted research studies on his days off that would bring him to the attention of the world's pain pioneers.

Remarkably, and despite being an unknown Australian lacking an exhaustive resume of publications in prestigious journals, he also attracted several grants from government agencies and industry in North America.[13] Likewise, at RNSH, his relentless stream of letters to Vanderfield eventually secured him permission and resources to conduct anaesthesia research and treat patients with chronic pain. Maybe he thought he could do the same in Adelaide, despite not being a heavyweight scientist at a respected university. As a new medical school and hospital, FMC was viewed as inferior by Adelaide's elite medical establishment. Moreover, Flinders's professors were considered 'new kids on the block' and 'lightweights'—scholars and practitioners who could not 'make it' in prestigious universities on the eastern seaboard.[14]

Several colleagues are convinced that Cousins accepted the role knowing the true situation. They suggest that his self-assurance, coupled with the example of his father and brothers and his experiences in North America and at RNSH, convinced him that he could establish and operate a pain centre against all odds. Disappointingly, we will never know the answers to these questions because, by the time this information was revealed after South Australia's state borders and FU archives reopened following pandemic lockdowns, Cousins was too elderly and incapacitated to be interviewed. He did not keep a diary or the offer letter, and, frustratingly, records of his job interview and the promises he believed were made to him were missing from FU's Gus Fraenkel Collection.

Meanwhile, on 15 April 1976, FMC welcomed its first inpatients.[15] It was a year after Prime Minister Gough Whitlam, leader of the Australian Labor Party, had broadened access to Australia's health system by introducing Medibank.[16] Pain as a field of medicine was still in its infancy. Two years earlier Bonica had founded the International Association for the Study

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[13] Philip Larson to F. R. Magarey, 9 July 1973, Cousins, Medical Biographies Collection.

[14] Boyle, interview.

[15] FMC, 'A Report of the Flinders Medical Centre April 1976 to 30 June 1979', 4; GF, Diary 1976, Fraenkel Collection.

[16] Australian Government, 'Medicare: Background Brief'.

of Pain (IASP) and in 1976, the association launched its journal, *Pain*, with Patrick Wall as its editor.[17]

Bonica was eager for local IASP chapters to form in each country to create a worldwide movement of pain medicine professionals. Around the time that FMC opened its doors to patients, Cousins suggested to Bonica that he launch an Australian chapter. Bonica encouraged his younger colleague enthusiastically, advising him to write a proposal for IASP councillors to consider at their next meeting. If the council 'tentatively' approved it, he wrote, the Australian chapter would be formally ratified at a pre-Congress Council meeting in Montreal in August 1978.[18]

Once he had secured the funds to pay them, Cousins was impatient to recruit team members.[i] Activating his professional networks, he 'handpicked' candidates with an impressive track record in research. One of the additional attributes he sought was a passion for teaching because he was eager for the Flinders's scientists and clinicians to match his efforts in educating doctors, nurses and allied health professionals about pain. The pool of potential candidates with this combination of skills was minute; however, he continually searched the globe for talented staff who shared his vision.

A 'master persuader'[19] and consummate networker, Cousins relied on his natural charm and infectious enthusiasm to garner support. Colleagues marvelled at his knack of bringing people into his orbit who would become almost like 'disciples', though some critics accused him of over-relying on his 'old boys' network'. Yet it was just one of the many tools he employed to help him achieve his goals; he capitalised on every opportunity available to him to pursue his agenda.[ii]

His most urgent priority was appointing specialist anaesthetists and visiting medical officers to work in the hospital's six operating theatres. He also recruited Garry Phillips, an intensivist, to head the intensive care unit. As a public hospital anaesthetist, Cousins was rostered in the operating theatres several days each week and was regularly 'on call' at night and on weekends.

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[17] Louisa Jones, *First Steps: The Early Years of IASP, 1973–1984* (Seattle: IASP Press, 2010), 12.

[18] JJB to MJC, 26 April 1976, Box 2, Folder 29, Bonica Papers.

[19] Mark Sullivan and Jane Ballantyne, *The Right to Pain Relief and Other Deep Roots of the Opioid Epidemic* (New York: Oxford University Press, 2023), 76.

In early 1976, when Josephine O'Grady joined FMC as Cousins's secretary, his phenomenal discipline and indefatigability astonished her. She remembered how he would arrive shortly after six o'clock in the morning on the days he was due in the operating theatre, afterwards returning to his office to tackle a myriad of administrative tasks and attend 'endless' meetings. Most days, he gave O'Grady dictaphone tapes of letters, memoranda, minutes of meetings, journal articles and chapters of his textbook to type. She described Cousins as serious, studious and self-assured, with a keen mind and driven by creative ideas for research. 'I couldn't believe one person could do so much', she remarked. 'He had extraordinary zest; my challenge was to keep up with him. I did my best for him as his secretary. He never took me for granted and often expressed his appreciation of my work.' O'Grady said working with Cousins was 'a very, very enjoyable experience'.[20]

In Cousins's 'good sized' office, O'Grady rested her notepad on his large tan leather-topped desk while taking dictation. An enormous oak bookcase overflowing with textbooks and journals covered the entire wall behind his desk. Though the office lacked a visitor's chair, a long rectangular wooden table and four upholstered chairs were positioned directly in front of the door into O'Grady's office and about three metres from Cousins's desk. Gold-framed medical degrees took pride of place along the wall next to the south-facing window that looked across to a thick stand of gum trees where rainbow lorikeets nested. Another door led into the anaesthetic laboratory where Cousins conducted methoxyflurane and halothane toxicity studies.

One of his early appointments was the Australian pharmacologist Laurie Mather, who had worked in Bonica's anaesthesia research group at UW. In an oral history interview two decades later, Bonica said Mather was one of the two best pharmacokineticists in local anaesthetics. The other was Geoff Tucker, whom Bonica also recruited. Mather and Tucker 'did the most important and most comprehensive studies on pharmacokinetics of local anesthetics', Bonica said. 'They're the world's authorities on it.'[21]

[20] Josephine O'Grady, interview by GKD, 22 September 2023.

[21] JJB, interview by John Liebeskind, 9–12 March 1993, Ms. Coll. no. 127.7, John C. Liebeskind History of Pain Collection, History & Special Collections Division, Louise M. Darling Biomedical Library, University of California, Los Angeles, 121.

Figure 9: John Bonica and Laurie Mather, 1986.

Courtesy Laurence Mather.

Mather resigned from UW in mid-August 1975, giving sixteen weeks' notice.[22] Nine months earlier, Bonica had penned a glowing reference for him to UW's promotion's committee. He knew Mather was under pressure to return to the University of Sydney as a tenured lecturer and he was eager to retain him. 'There is little question that, currently he [Mather] is one of the foremost authorities on the pharmacokinetics of local anaesthetics', Bonica wrote.[23]

One week after receiving Mather's resignation, Bonica fired off a furious letter to Cousins, admonishing him for recruiting Mather midway through the American academic year. Insisting the usual notice period was eighteen months, Bonica claimed Mather's imminent departure meant crucial pharmacokinetics research would flounder until the department found someone to replace him.

Bonica had written an enthusiastic reference to FU to support Mather's application for the position of inaugural lecturer in anaesthesia.[24] However, he clearly did not expect his prize recruit to leave Seattle so soon. Despite Bonica's anger, Mather returned to Australia at the end of the year, commencing at Flinders two months later.[25]

Cousins's intransigence in the face of Bonica's protests is startling because he coveted the close relationship he shared with his mentor. The 'Grand Man' was so intimidating that most people simply complied with his demands: few had the fortitude to disobey him. That Cousins was

[22] L. Mather to JJB, 13 August 1975. Laurence Mather Private Collection.

[23] JJB to Robert Van Citters, 14 November 1974, Box 6 , Folder 109, Bonica Papers.

[24] JJB to H. Buchanan, 10 June 1975, Laurence Mather Private Collection.

[25] JJB to MJC, 22 August 1975, Box 25, Folder 27, Bonica Papers.

willing to infuriate Bonica indicates the depth of his mettle.[iii] Fortunately for him, Bonica still referred to him as his 'good friend' in a letter to Mather two months later.[26]

Mather's appointment 'raised a few eyebrows', according to Cousins, especially those of Fraenkel, who had expected an anaesthetist to lead the anaesthesia research effort. Despite Fraenkel being a determined administrator and powerful negotiator,[27] Cousins ignored his protests, confident in Mather's ability to build a pre-eminent scientific program. It proved to be a wise choice, heralding the birth of a triumphant three-decades partnership that would see the pair attract millions of dollars in funding and forge new territory in anaesthesia and pain research.

From Mather's first day, he and Cousins proceeded in parallel to set up the new academic anaesthesia department, with Cousins managing clinical matters and interacting with hospital administrators. Thirty-two-year-old Mather led the scientific program and liaised with the university.[28] The pair accepted that research funding would underpin their progress, so together and separately they applied for grant after grant to support their endeavours. Bemoaning the uncertain and prohibitive cost of scientific research, Mather coined the phrase 'the elephant in the laboratory' to portray the perpetual search for funding.[29]

Mather and Cousins agreed that whenever they believed a pharmaceutical company's products could promote patient care through further research, they would apply for grants from these organisations. This largesse, which they accepted on the condition that the company could not influence the research design or results, would enable them to acquire infrastructure that boosted their competitiveness against more established research groups when applying for National Health and Medical Research Council (NHMRC) grants. Four decades later, Mather believed his collaboration with Cousins succeeded because they shared a common goal: 'To create an environment that would advance patient care and concurrently advance science.'[30]

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[26] JJB to L. Mather, 27 August 1975, Laurence Mather Private Collection.

[27] John Chalmers, 'Gustav Julius (Gus) Fraenkel', *Australian Dictionary of Biography* (2022), National Centre of Biography, Australian National University, published online 2022, https://adb.anu.edu.au/biography/fraenkel-gustav-julius-gus-32501.

[28] L. Mather to GKD, personal communication, 22 August 2023.

[29] L. Mather, 'Stereopharmacological Research in Anaesthesiology' (Doctor of Medical Science thesis, University of Sydney, 2015), 24.

[30] L. Mather, interview by GKD, 25 January 2019.

In late 1976, Mather appointed the biochemist and computer analyst Kevin Austin as the department's first hospital-funded scientist. Austin developed the department's early computer systems and computerised its patient records in collaboration with Garry Phillips. The anaesthesia department's terminal and printer, which linked with the university's mainframe, operated at what Mather later described as the 'spellbinding speed of 1,200 baud and printing at 300 baud'. Despite its glacial speed, it enabled them to conduct the pharmacokinetic analysis they required in their studies.

Four years later, at Mather's suggestion, the anaesthesia department became the first at FU to purchase a standalone word processor—an NBI OASys 3000—a dual eight-inch floppy disk computer running on a proprietary operating system. It impressed everyone who saw it, including Fraenkel, who pronounced that it was 'expensive, but probably the way of the future'.[31]

Mather's second recruit was Colin McLean, a laboratory technician who managed the analytical chemistry lab for the pethidine and other drug studies. McLean, whose salary was funded by FU, assisted Mather in a myriad of ways, including setting up and performing experiments and conducting laboratory teaching demonstrations. 'Kevin's and Colin's roles started with no "team"', Mather remarked. 'The "team" grew year by year over the first five or so years.'[32]

Contemporaneously, Cousins recruited Anne Fulton as a research assistant in his laboratory. He continued the anaesthetic toxicity research he had started in Stanford; however, he was eager to switch to conducting studies on novel treatments for acute postoperative pain. Somewhat disappointingly for him, he had to delay these studies because the NHMRC awarded him $10,000 to study the toxicity of halothane on the liver. Over the next six years, the NHMRC would provide nearly $120,000 in grants for this research, which would be around $650,000 today.[33]

In 1977, Cousins appointed Geoff Gourlay as a hospital scientist. Gourlay specialised in biochemical pharmacology and drug metabolism and the pair collaborated on halothane

[31] Mather, 'Stereopharmacological Research in Anaesthesiology', 104.

[32] L. Mather to GKD, personal communication, 20 June 2019.

[33] MJC, 'Curriculum Vitae: Professor Michael Cousins AO', 2016, 8–9, Cousins, Medical Biographies Collection.

toxicity research. Their laboratory was equipped with analytical instruments such as the gas-liquid chromatograph Cousins had brought from Sydney. Frustratingly for Mather, Austin and McLean, they worked in 'rather bare' laboratories for several months until sufficient funds were available to purchase equipment. To conduct experiments, they borrowed apparatus from other laboratories across the hospital that were equally barren and accessed instruments from the highly popular 'common pool' of analytical tools the hospital provided.

Mather's research in applied pharmacology focused on exploring the effects of a drug on the body and the reciprocal effects of the body on a drug. To conduct his studies, he required reliable practical tools, such as gas-liquid chromatography, to measure minute quantities of drugs in blood samples. Whenever Cousins, Fulton or Gourlay were not using the device in their lab, Mather borrowed it, though he urgently required one of his own.[34] While Mather waited for laboratory equipment to materialise, FMC's microbiology department invited him to collaborate on an F. H. Faulding & Co–funded analysis of the then-novel antibiotic, erythromycin. This project gave him much-needed research credibility in the new medical school.[35]

Mather continued his UW studies on postoperative pain, and, towards the end of 1976, he received a $25,000 grant from the Astra Pharmaceutical Company, the major maker of local anaesthetic agents internationally. The organisation's head office was in Sweden. During the next eleven years, it would provide today's equivalent of $870,000 to Mather and Cousins for research on local anaesthetic products.[36] Astra funding meant that Mather could purchase computers and software programs for analysing data, and, vitally, a gas-liquid chromatograph. This enabled the team to study the effects of pethidine on the body, and the body on pethidine, prompting Austin to embark on a PhD about the effects of pethidine on postoperative pain. The university's research committee also provided $11,500 for equipment and maintenance.[37]

The pethidine studies, like most of FMC's anaesthesia investigations, were multidisciplinary, involving benchtop and clinical researchers, postgraduate students, lab technicians, pathologists, biochemists, pharmacologists, anaesthesia fellows and nurses working

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[34] L. Mather, interview by GKD, 16 April 2019.

[35] Mather, 'Stereopharmacological Research in Anaesthesiology', 32.

[36] Mather, 'Stereopharmacological Research in Anaesthesiology', 32; MJC, 'Curriculum Vitae: Professor Michael Cousins AO', 2016, 11.

[37] Mather, 'Stereopharmacological Research in Anaesthesiology', 22.

collaboratively. At any time, six or more team members would assemble around a research subject's bed completing tasks, such as inserting cannulas, injecting pethidine, sampling blood, measuring blood gases and monitoring physiological recorders.[38]

At first, FMC's anaesthetists were reluctant to collaborate with Mather because, as medical graduates, they were not accustomed to viewing a scientist as a peer. This elitism created an impasse until Cousins, the 'master problem solver', according to Mather, assigned the anaesthesia registrar John Stapleton as a research fellow. Stapleton's appointment enabled Mather 'to make serious progress' with the pethidine studies. In 1977, the pair received a $4,000 grant from the Australian Society of Anaesthetists to embark on their investigations.[39]

The same year, Phillips recruited the anaesthetist Bill Runciman as an intensive care specialist. Runciman became the department's second doctoral student when he commenced a PhD project on the effects of adrenaline infusions for intensive care patients struggling with septicaemia. When this research foundered because of methodological issues, he joined Mather in a project using sheep as experimental subjects to study the physiological changes caused by anaesthesia on drug behaviour.

A 'big believer in animal studies' after his experiences at Stanford, Cousins helped to raise funds to develop a state-of-the-art sheep lab, enabling Mather and Runciman to spend the next decade conducting NHMRC and 'big pharma'–sponsored drug trials. These investigations enabled them to co-supervise several PhD projects designed to answer questions such as: 'Where in the body are drugs such as pethidine cleared?' and 'What are the effects of general and spinal anaesthesia on regional blood flow and oxygen consumption?'[40]

[38] L. Mather to GKD, personal communication, 19 September 2023.

[39] Mather, 'Stereopharmacological Research in Anaesthesiology', 22.

[40] Mather, 'Stereopharmacological Research in Anaesthesiology', 20.

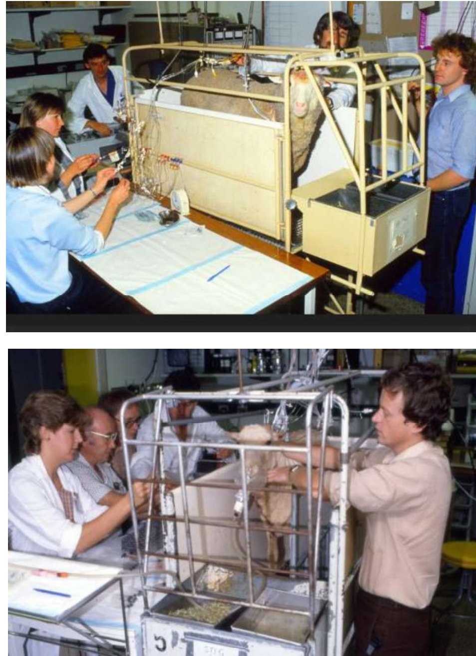

Figure 10: 'Sheep Lab' studies at Flinders Medical Centre, 1970s.

Courtesy Laurence Mather.

Meanwhile, despite limited resources and opposition from FMC's hierarchy about setting up a pain centre, Cousins charged ahead, single-mindedly pursuing his agenda. 'Michael was a goal-setter and steadfast in achieving every goal he set himself', Gourlay observed. 'Sometimes etiquette was subservient to his driving goal. One cannot but admire his zeal in attacking the problems he saw; however, his uncompromising approach alienated some people.'[41]

Colleagues from Adelaide's elite private schools, the University of Adelaide and Royal Adelaide Hospital did not appreciate Cousins's arrival, attested Reeve, who said they expected this 'upstart' from Sydney to serve his time and prove himself before they would support him.[42] O'Grady recalled that FMC department heads were ambitious young men in their thirties and forties, and they all excelled in their field of medicine. 'There were some big egos, and they were all out getting the best for medicine. Of course, clashes occurred between them. That was to be expected.'

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[41] Gourlay, interview.

[42] Reeve, interview.

O'Grady observed how Cousins's efforts were often stymied by colleagues from Adelaide's establishment; however, she was struck by his polite persistence and composure. 'Michael was always courteous and gracious, even under the most testing circumstances', she recalled:

> I could sense the tension between him and another person if there was no love lost between them, but I never heard him raise his voice or get visibly angry. Whenever he encountered obstacles, he'd generate another opportunity to present his case or skilfully navigate around the blockade.[43]

Seemingly unperturbed by the hurdles, and in a bold move, Cousins 'borrowed' a small area of the outpatient department for consultations with pain patients. He also commandeered a corner of the operating theatre's recovery ward for procedures such as nerve blocks and epidural analgesia. 'I inveigled a physiotherapist to work with me, who was superb', he said in an oral history interview twenty-one years later. 'I managed to borrow some nursing staff and operating theatre time. I remember I had to do nerve blocks in a side theatre while I was supervising a resident administering general anaesthesia in an adjacent operating theatre.'[44]

Fortunately, his vigorous lobbying for anaesthesia research laboratories had secured a generous space for them, so he used some of this allocation for pain management consultations.[45] Accommodating outpatients in this 'unsatisfactory temporary accommodation', he completed 125 pain management procedures in 1976.[46]

At times, Cousins, though usually so positive and optimistic, despaired of ever achieving his goal of setting up a world-class pain centre. In a late-night phone call with Bonica, he confided his despondency and sense of defeat. 'Search for funding in every nook and cranny', Bonica advised. 'Even view patients as potential donors.' During that conversation, Bonica invited him to become chair of IASP's finance committee. Decades later, Cousins recalled his surprise at this offer because ten minutes earlier he had revealed his failings. Still, he was eager for IASP, which 'ran on a shoestring',[47] to fund innovative research and education programs. In accepting the role, he sensed his workload would soar because of Bonica's expectation that IASP office-

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[43] O'Grady, interview.

[44] MJC, interview by M. Meldrum, 13.

[45] O'Grady, interview; Gourlay, interview.

[46] FMC, 'A Report of the Flinders Medical Centre April 1976 to 30 June 1979', 6.

[47] Jones, interview.

bearers match his fiendish work ethic.[48] Despite this suspicion, Cousins felt ready to rise to the challenge.

On the home front, life was equally busy. Total responsibility for raising James, Jonathan and Richard and keeping Highfield 'shipshape' fell to Michele. Occasionally, she played tennis or attended an exercise class; however, she had little free time to pursue her own interests. James was a talented athlete on the track, and he also played Australian Rules football and, later, hockey. Though Cousins occasionally ferried his eldest son to training and matches and stayed to watch him, it was Michele who devotedly transported their sons to after-school and weekend sporting activities.[49]

Late on Saturday mornings, Cousins would mow Highfield's lawn. The house was built on a three-quarter acre block of land, so it took nearly two hours to mow all the grass. One sweltering summer day, Michele told her husband that she had to spend four hours each week sweeping up all the leaves in their garden. Acknowledging that she loathed this thankless, never-ending chore, he bought a noisy device to 'vacuum' the leaves. From then on, he assumed responsibility for 'leaf control', which he enjoyed because it gave him uninterrupted thinking time, some of it plotting his next move.

Figure 11: (L to R) Jonathan, Michael, Michele, James and Richard Cousins, 1976.

Photographer: David Simpson. Courtesy Michael and Michele Cousins.

[48] JJB to R. Melzack, 4 February 1980, Box 4, Folder 120, Bonica Papers.

[49] Michele Cousins, interview by GKD, 1 May 2019.

The psychologist Ross Harris had joined FMC in its primary care and community medicine department in 1975. Harris and Cousins bonded, and so began another multi-decade partnership. The pair often talked about the psychological impacts of chronic pain. Cousins knew he should provide psychological services to patients; however, he did not have enough funding to pay a psychologist. Harris, who had witnessed the benefits of cognitive behavioural therapy during his postgraduate studies in America,[50] offered to help. Generously, he volunteered to provide counselling in the pain unit on the days he was not due in the hospital's psychology clinic. Cousins was ecstatic, gratefully accepting this kind offer.

Four decades later, Harris said his suggestion reflected one of the forward-looking and unique features of 'FMC's model': joint problem-solving between department heads. 'When a particular unit faced an issue, all the senior managers collaborated to solve it', he explained. 'It proved to be a wonderful, levelling influence that meant creative thinking from various scientific and medical disciplines was available to everybody. To the extent to which it was realistic and feasible, we assisted and supported one another.'

Collaborating within a multidisciplinary pain team was a novel experience for Harris and one he admired:

> The model Michael Cousins brought to Australia was extraordinarily up-to-date and creative. Helping someone manage their pain and navigate their way through pain and out of pain was a new notion to me. It was a wonderful experience to be part of this quite broad group of professionals striving to meet age-old problems with a new kind of methodology. I found a remarkable group of people at Flinders and Michael Cousins was one of the shining stars among them.[51]

To Cousins's immense relief, some of the anaesthesia and psychiatry peers he cultivated offered their expertise pro bono during their nonclinical sessions—usually one or two afternoons each week. 'I realised I'd need to use my personal relationships to win over support and cobble services together', he said. 'It came down to twisting arms and making my colleagues feel they could contribute. It was just a matter of goodwill.'

He appreciated the generosity of like-minded associates who volunteered their time to enable the delivery of pain services. Yet the pain management offered through the altruism of a few

[50] Cognitive behaviour therapy employs a 'problem-solving approach to the identification of thoughts and behaviours that underpin psychological problems'. Harris, Nagy and Vardaxis, *Mosby's Dictionary of Medicine*, 391.

[51] Ross Harris, interview by GKD, 30 August 2019.

sympathetic allies was a far cry from the premier multidisciplinary pain centre he intended to build. Nevertheless, during 1977, the number of outpatients who received pain management services increased fivefold compared with 1976. The following year, it increased by another fifty percent.[52]

This did not surprise Garry Phillips. In 1999, Phillips penned a piece for the medical school's twenty-fifth anniversary: 'Michael Cousins addressed his portfolio with vigour. Within 12 months, in addition to Clinical Anaesthesia and Intensive Care Services, he had laid the foundation for the Pain Management Unit and planned a broad and aggressive program of teaching and research.'[53]

In November 1977, Bonica congratulated Cousins on convincing two Australian anaesthetists—Chris Glynn and Peter Wilson—to return to Australia from acclaimed pain medicine centres overseas. Glynn's postgraduate experience had been with the prestigious Oxford Pain Relief Group in England, and Wilson had spent several years at the Mayo Clinic in America, where he conducted pioneering epidural anaesthesia studies with Tony Yaksh, an acclaimed researcher. Glynn and Wilson would profoundly influence Cousins's career. 'I am very pleased to learn that you are building up a strong team in pain research and therapy', Bonica wrote. 'From your description of the qualifications, Drs Glynn and Wilson should constitute a strong nucleus for a major program.'

In that letter, Bonica also thanked Cousins for submitting his proposal to form an Australian chapter of IASP and fulfilling the requirements, which included sending twenty-five signed petitions supporting recognition of the chapter. 'Please proceed with haste because it is very important to support the worldwide movement on pain, which is gaining momentum', Bonica wrote. 'Look forward very much to having the Council consider the application of the Australian Chapter and to have your colleagues attend the Second World Congress in Montreal.'[54]

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[52] FMC, 'A Report of the Flinders Medical Centre April 1976 to 30 June 1979', 30.

[53] Gary Phillips, 'Anaesthesia and Intensive Care', *Reflections of the Flinders School of Medicine* (April 1999): 58, Laurence Mather Private Collection.

[54] JJB to MJC, 7 November 1977, Box 2, Folder 29, Bonica Papers.

Shortly afterwards, Bonica telephoned Cousins, inviting him to become vice president of IASP's Asia Pacific Region. Bonica had established several vice president positions around the world to ensure he received responses from IASP members living in 'far away places'.[55] Though Cousins felt flattered, he hesitated because of Bonica's exacting standards, which he had learned through his role as head of IASP's finance committee. 'I'm very busy', he pleaded. 'I'm setting up a new department, fundraising and editing the neural blockade textbook, so I shouldn't take on too much more.'

Bonica was indignant. 'Listen, son. Are you going to do it? Yes, or no?'

'I think I'd better do it.'

Cousins remembered that was how Bonica recruited all the association's office-bearers. 'Not one person was game to turn him down.' This would not be the last time he succumbed to Bonica's force of personality or his own ambitions, despite the workload implications.

On 10 April 1978, Connie Peck, a clinical psychology lecturer at La Trobe University in Victoria, announced a 'preliminary call for papers' for Australia's first national multidisciplinary conference on pain, to be held in early December 1978.[56] She posted the announcement to departments of psychology, psychiatry, surgery, dentistry, pharmacology, anaesthesiology, physiology and medicine throughout Australia.

Peck had arrived at La Trobe University in 1977 after spending two years at UW's Department of Rehabilitation Medicine collaborating with the psychologist William Fordyce, who pioneered behavioural psychology approaches to managing chronic pain.[57] Once in Melbourne, Peck had become involved in a multidisciplinary pain project at the Royal Southern Memorial Hospital with Jack Nayman, the hospital's chief of surgery, whose research included postoperative pain relief. The anaesthetist Robert Hare and George Singer, founding chair of

[55] JJB to Patrick Wall, 8 August 1975, Box 6, Folder 129, Bonica Papers.

[56] Connie Peck, 'Call for Papers: First Australia-New Zealand Conference on Pain', 10 April 1978, Box 25, Folder 27, Bonica Papers.

[57] William Fordyce oversaw Bonica's pain rehabilitation program at UW, spearheading the treatment of chronic pain through behavioural psychology, which involves using social reinforcers to change pain behaviours. Daniel B. Carr and Michael J Cousins, 'The Anesthesiologist and Pain: A Historical Memoir', in *The Wondrous Story of Anesthesia*, ed. Edmond I. Eger II, Lawrence J. Saidman, Rod N. Westhorpe (New York: Springer, 2014), 816.

La Trobe's psychology department, also participated in these studies.[58] The group started hosting evening meetings each quarter with other pain researchers and clinicians from Melbourne. During one of these gatherings, Jack Nayman suggested they organise Australia's first national conference on pain.[59]

In the preliminary call for papers, Peck noted: 'At the time of the conference we hope to organise a society in Australia which can affiliate with one of the international organisations such as the IASP.'[60]

Four weeks later, Peck wrote to Bonica, inviting him to be the keynote speaker, the only invited speaker.[61] She also enclosed the 10 April announcement. One week after Peck posted the letter, Rosita Walsh, Bonica's secretary, replied to her, informing her that Bonica would respond in early July after returning from one of his frequent overseas lecture tours.[62]

Bonica wrote to Peck on 11 July, explaining that he could not travel to Australia in December because he was due in New York to chair a scientific meeting. He asked if it was possible to change the conference date to coincide with his trip to Australia from 30 October to 19 November 1978.[63]

By 17 July, however, Peck had not received this reply, so she sent a follow-up letter to Bonica. 'We are still hopeful that you will be able to accept our invitation to be guest speaker for the conference', she wrote, enclosing pre-registration information for the 'First Australia–New Zealand Conference on Pain'. Included in this information was the following paragraph: 'A conference dinner is planned for the evening of 2 December and a business meeting to discuss forming an organisation and future conferences will be held in the afternoon of 3 December.'[64]

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[58] Connie Peck, 'The First Australia-New Zealand Conference on Pain', *Australian Pain Society Newsletter*, March 2009, Connie Peck Private Collection.

[59] C. Peck to GKD, personal communication, 28 August 2023.

[60] C. Peck, 'Call for Papers: First Australia-New Zealand Conference on Pain'.

[61] C. Peck to JJB, 8 May 1978, Box 25, Folder 27, Bonica Papers.

[62] Rosita Walsh on behalf of JJB to C. Peck, 16 May 1978, Box 25, Folder 27, Bonica Papers.

[63] JJB to C. Peck, 11 July 1978, Box 25 Folder 27, Bonica Papers.

[64] C. Peck to JJB, 17 July 1978, Box 25, Folder 27, Bonica Papers.

On 26 July, Rosita Walsh wrote to Peck, suggesting Bonica's letter to her must have 'crossed in the mail'. She informed Peck of Bonica's inability to speak at the conference.[65] The same day, after receiving Bonica's original response, Peck replied, noting it was too late to change the date of the conference because she had already distributed the call for papers, and it would cause too much confusion. In that letter, she invited him to join a group of pain clinicians and basic scientists at La Trobe University for lunch during his Australian visit.[66]

While Peck does not remember this series of letters, she recalls receiving a missive from Bonica a 'couple of months' before the conference. In the letter, which no longer exists in Peck's personal papers or in the Bonica Papers, Bonica 'implored' her to 'not split' the Australian pain community. He also informed her that Cousins was making good progress in planning the first scientific meeting of the 'Australasian Chapter' of IASP, which would take place in May 1979.

Peck outlined her memory of Bonica's note in an email, remarking that she was 'somewhat shocked' by it. 'Our whole idea was to establish a community of pain experts, not to cause any ruptures within that group', she wrote.[67]

Around the same time as Bonica's letter arrived in Peck's narrow psychology department pigeonhole, she received a surprising one from Cousins, who claimed he had not known about the La Trobe conference. She read a mirror image of Bonica's remarks about the 'Australasian Chapter' (later renamed the Australian Pain Society) and that Cousins was advanced in planning its first scientific meeting.

It is implausible to think that Bonica would have omitted mentioning anything to Cousins about the La Trobe group's planned conference or side meeting. Peck had included details of the 'business meeting' in the preliminary call for papers she sent in her 8 May letter to Bonica. The same letter was distributed widely within Australia's nascent pain medicine community, which was so small one would have expected news of the nation's first multidisciplinary pain conference to spread like wildfire.[68] So why did it not arrive at Flinders? Or maybe it did, and

[65] Rosina Walsh on behalf of JJB to C. Peck, 26 July 1978, Box 25, Folder 27, Bonica Papers.

[66] C. Peck, to JJB, 26 July 1978, Box 25, Folder 27, Bonica Papers.

[67] C. Peck to GKD, personal communication, 28 August 2023.

[68] C. Peck, 'Call for Papers: First Australia-New Zealand Conference on Pain'.

Cousins either did not see it or ignored it? Surely someone in the Flinders's anaesthesia department would have read it and told him about it?

The historian Judith Godden, whom the Australian Pain Society (APS) later contracted to write *Australian Pain Society: The First 35 Years*, mentioned a September 1978 letter in which Cousins informed Peck of the first Annual Scientific Meeting of the new Australasian Chapter of IASP. Yet Godden did not provide a reference for this letter.[69] The citation she included at the end of the chapter was 'Cousins, Michael and Connie Peck, correspondence October–November 1978'.[70] She did not provide the date of the letter or its contents. In an email, Godden wrote:

> Sorry I haven't kept any original material that I saw at APS. I don't think (from memory) that the documents shed much light on the issue you raise but a factor to consider is that it was the 1970s and Connie was female and not a medical doctor. My impression (from memory) is that she tried to set up the society and meetings were held before and along with the conference, but that Michael had the international contacts and medical cred, so his was the first 'official' organisation. I don't recall him mentioning Connie Peck and perhaps he simply sidestepped her.[71]

Peck confirmed that she responded to Bonica's and Cousins's letters, noting that the La Trobe group knew nothing of plans for the 'Australasian Chapter' and had no intention of undermining Cousins's efforts. 'We simply wanted to bring those working in the field together, nothing more', she wrote to Cousins, suggesting they meet to resolve the issue. He replied, confirming that Peter Wilson would represent him at a meeting with her, Singer and Nayman. One week later, Wilson flew to Melbourne to meet with the La Trobe group.

Over wine, cheese and crackers at Nayman's home, Singer explained to Wilson how the idea for the La Trobe conference had arisen and that the group did not know about Cousins's efforts to establish a local IASP chapter. Singer affirmed that the La Trobe group had no intention of causing any problems within Australia's pain community. Peck recollected 'an idea being mooted' that the December conference proceed, though it would be referred to as a 'lead-up' to the May 1979 conference. 'The title of the first meeting of IASP's Australasian Chapter

[69] Judith Godden, *Australian Pain Society: The First 35 Years* (Sydney: Australian Pain Society, 2015), 35.

[70] Godden, *Australian Pain Society*, 42.

[71] Judith Godden to GKD, personal communication, 14 August 2023. On page 35 of *Australian Pain Society*, Godden mentioned a letter Chris Glynn wrote on 20 December 1978 on IASP letterhead, affirming the Montreal meeting had 'ratified' the formation of an Australasian Chapter. However, Godden did not provide the citation for this letter.

would be reserved for the conference Cousins was organising', she wrote. Peck recalled Wilson phoning Cousins from the privacy of Nayman's bedroom to 'sound him out' about this proposal. When Wilson returned to the living room, he confirmed that Cousins had agreed with it.[72]

Recalling this time in 2023, Peck wrote:

> We were not *per se* trying to set up an Australasian Chapter of the IASP; I don't even know if we knew about IASP chapters. Rather, as I recall, we were just planning to hold a conference of those in the field, with the idea that perhaps it would become something regular. We were initially planning to discuss what form this would take with the group who attended at the end of the conference itself.[73]

However, in a 2009 article in the *Australian Pain Society Newsletter*, she recalled things differently:

> Our hope was not only to organize a useful conference, but also to use this as a vehicle for creating a new pain society which would become an affiliate of the IASP and advance our knowledge in understanding and treating pain problems.[74]

Moreover, in 2009, Amal Helou, the society's president at the time, wrote the following statement in Peck's APS Distinguished Member award citation: 'She [Peck] also began to organise quarterly meetings of pain researchers and clinicians, which led to the idea of creating a Multidisciplinary Pain Society in Australia and New Zealand, to be affiliated with the IASP.'[75] When questioned about the accuracy of this statement, Peck responded:

> We did hope eventually to become part of the IASP but didn't know about chapters, etc. and we were waiting until the first conference to discuss it further with those who attended—that is, until we found out that Michael had already done all of that! So, I guess the whole point was that Michael was further along with getting an affiliation with the IASP and we were further along in terms of timing with organising a conference. But as I said, we ultimately found a way to make it all work.[76]

Nevertheless, in *Australian Pain Society. The First 35 Years*, Godden wrote: 'It was with the founders the calibre of Sir Sydney Sunderland and Professor Michael Cousins, and the

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[72] C. Peck to GKD, personal communication, 28 August 2023.

[73] C. Peck to GKD, personal communication, 28 August 2023.

[74] Peck, 'The First Australia-New Zealand Conference on Pain'.

[75] Australian Pain Society, '2009 Distinguished Member Awards', Connie Peck, accessed 1 August 2023, https://www.apsoc.org.au/PDF/Distinguished_Members/2009_DistMembProg09_Final_PECK_Connie.pdf.

[76] C. Peck to GKD, personal communication, 29 August 2023.

contribution of another internationally renowned figure, Dr Connie Peck, that the Australasian Chapter of the IASP began.'[77]

It took five years and dozens of failed Google searches and unanswered emails to find Peck, who is retired from her decades-long conflict resolution career with the United Nations and now lives in France. By 2023, when Peck was finally located, Nayman and Singer had died, and Cousins was too elderly and incapacitated to re-interview. Exhaustive attempts over five years to interview Peter Wilson also failed. After finally locating him, he did not reply to interview invitations.

Disappointingly, two APS presidents denied repeated requests over five years to access the society's archives and the letters Godden mentioned. They raised concerns about 'potential breach of confidentiality and occupational health and safety issues', among others, as the grounds for denial. The inability to corroborate crucial memories about this decades'-long grievance is regrettable because it undermines the integrity of the historical record.

In an interview in 2023, Helou suggested that the obvious 'angst' between Cousins and the APS, including its resistance to allowing his biographer to access its archives, resulted from Cousins's 'self-interest'. 'Michael Cousins did some good things for the pain world', Helou admitted, 'but the tail end of anything he did good was his self-interest. His self-interest extended to him personally and the pain centres he led.'[78]

Two other pain professionals expressed a similar sentiment when declining an interview invitation and three critics made similar remarks during interviews. Yet, when questioned about these comments, the greater majority of colleagues strongly rejected them, insisting that Cousins was driven by humanitarian ideals: reducing suffering by improving the treatment of pain, rather than personal advancement. They agreed he was ambitious, competitive and fiercely single-minded; however, they asserted it was these character traits that enabled him to overcome the formidable obstacles he faced in advancing pain medicine.

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[77] Godden, *Australian Pain Society*, 27.

[78] Amal Helou, interview by GKD, 14 September 2023.

On 27 August 1978, IASP held a council meeting at the Queen Elizabeth Hotel in Montreal, the day before its Second World Congress on Pain began in the hotel. Surprisingly, Cousins did not attend. This is puzzling because he was to be appointed as one of IASP's six vice presidents to replace Sir Sydney Sunderland, who was retiring. A renowned neuroanatomist known as 'the father of modern nerve surgery', Sunderland was Australia's first IASP councillor.[79]

The reason for Cousins's absence is unclear. In a 2019 interview, he said it might have been a lack of travel funds; however, another possibility Chris Glynn suggested is a sudden pilot strike in Canada. Fraenkel noted in his diary on 26 August that his flight from Vancouver to Winnipeg was cancelled because of the strike, and Jones mentioned how the strike had prevented several European delegates from attending the Montreal Congress, so this is the most likely explanation for Cousins's absence.[80] Usually, on the rare occasions Cousins could not attend an IASP congress or council meeting, he wrote a letter of apology to Bonica. However, the archives do not contain an apology letter in relation to the Montreal Congress. Nevertheless, at the meeting, and in Cousins's absence, councillors agreed to ratify the formation of IASP's Australasian Chapter.[81]

At the council meeting, its members appointed Cousins as the Australasian Chapter's interim president and Glynn as secretary. Once Glynn returned to Australia, he and Cousins set to work creating the chapter, though, as secretary, Glynn carried most of the day-to-day workload.[82] Sunderland, who accepted Cousins's invitation to serve as foundation president, assisted Glynn and Cousins to create a draft constitution that defined the organisation's goal: 'To improve pain management by fostering pain research and education and developing clinical standards.'[83] From the start, the Australasian Chapter replicated Bonica's priorities.[iv]

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[79] Ross Jones, 'Sunderland, Sir Sydney (Syd) (1910–1993)', *Australian Dictionary of Biography*, National Centre of Biography, Australian National University, published online 2017, https://adb.anu.edu.au/biography/sunderland-sir-sydney-syd-26721/text34360.

[80] GF, diary entry, 26 August 1978, Fraenkel Collection; Jones, *First Steps*, 19. See also Chris Glynn, interview by GKD, 5 December 2022.

[81] Raymond Fink, 'Annual IASP Secretary's Report', 17 August 1978, Box 55, Folder 31, Bonica Papers; R. Fink, 'Minutes: IASP Council Meeting, Montreal', 27 August 1978, Box 55, Folder 28, Bonica Papers.

[82] Glynn, interview.

[83] Godden, *Australian Pain Society*, 26.

Within three months of the Montreal meeting, Bonica visited Australia to present a frenetic schedule of meetings and keynote addresses at various symposia on the latest advances in pain management.[v] He was also scheduled to conduct clinical demonstrations of regional anaesthesia procedures in hospitals in Sydney, Melbourne and Adelaide. While in Adelaide, he and his wife Emma stayed at Highfield[84] and Bonica spoke with the medical writer from Adelaide's newspaper the *Advertiser*. The following day, 8 November 1978, the *Advertiser* published 'Attitude to Pain Inappropriate'.

In the article, Bonica criticised the Western world's 'stiff upper lip policy to pain', urging doctors and society at large to appreciate that recent pain research had resulted in the creation of effective new treatments. Praising FMC's pain team, he claimed it was one of the most outstanding departments for pain research and treatment in the world. 'I hope Australia realises this', he remarked, 'and supports research at the centre'.[85]

The pain control group of Astra Lakemedel AB (now part of AstraZeneca), sponsored Bonica's worldwide lecture tour from its head office in Sweden.[86] Bonica and Astra aimed to stimulate interest in pain research and uptake of regional anaesthesia for postoperative pain management, general surgery, obstetrics, urology and orthopaedics.[87] Bonica used the company's products in the regional anaesthesia procedures he demonstrated during his travels, prioritising visits to hospitals and clinicians where regional anaesthesia was not already practised.[88]

The morning after Bonica's and Cousins's late-night flight from Adelaide to Melbourne, the Flinders team's research on using computer-designed intravenous infusions of pethidine to control postoperative pain featured on the front page of the Adelaide *News* with a headline that Mather cringingly referred to as 'screaming'—'SA Team Smashes Pain Barrier'.[89] Adelaide's *Advertiser* announced: 'Triumph by Adelaide Research Team. They've Broken the Pain Barrier. Doctors find key to post-operation relief.' At the top of the article, the *Advertiser* displayed half-page photographs of Mather, Austin and Stapleton wearing pristine white lab

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[84] JJB, 'Itinerary for Australia and New Zealand Trip', 10 June 1978, Box 25, Folder 7, Bonica Papers, 118.

[85] Barry Hailstone, 'Attitude to Pain Inappropriate', *Advertiser,* 8 November 1978, 10.

[86] JJB to Hans Claesson, 3 January 1979, Box 25, Folder 26, Bonica Papers.

[87] JJB to Jeays Lilley, 3 January 1979, Box 25, Folder 26, Bonica Papers; JJB to Jeays Lilley, 6 October 1978, Box 25, Folder 26, Bonica Papers; Jeays Lilley to JJB, 15 August 1978, Box 25, Folder 26, Bonica Papers.

[88] Michael Millar to JJB, 27 April 1978, Box 25, Folder 26, Bonica Papers.

[89] 'SA Team Smashes Pain Barrier', *News,* 8 November 1978, Laurence Mather Private Collection.

coats over crisp shirts with large stiff collars and wide ties, their lab coat pockets brimming with pens and gadgets.

The photos captured Mather in mid-action pushing buttons on a then state-of-the-art gas chromatograph and watching the pethidine analysis unfold on a graphical plotter. Next to it was an image of Austin typing data into a computer terminal. Stapleton stood at the head of a patient's bed while checking the progress of a drug infusion device connected to a catheter in the patient's right arm. The captions under each photo read: 'Dr Laurie Mather … began research', 'Dr Kevin Austin … special interest in computers' and 'Dr John Stapleton … carried out clinical studies'.

Cousins was quoted in large bold letters at the top of the article: 'Possibly the most significant development in the post operative pain field for 100 years.' Next to it was Mather's more circumspect remark: 'It's less important developing new pain-killing drugs than using existing ones more effectively.'[90]

Dramatic headlines also appeared across the nation on the front page of the *Sydney Morning Herald*[91] and *Daily Mirror.*[92] Each of the medical writers reported that FMC's studies explained why an intravenous infusion of pethidine given to a patient after surgery provided superior pain relief to the conventional practice of injecting pethidine into a muscle every few hours.

Much to Mather's humiliation, several departmental colleagues ridiculed the *News* article, which was amusingly satirised in the annual *Flinders Arts Review* that year. Decades later, Mather admitted he was naive in his dealings with the journalists, never suspecting the research results would be sensationalised.[93] His chief concern was that populist media coverage would create unrealistic expectations about pain relief and tarnish the reputation of Austin, Stapleton and himself as rigorous researchers at a vital stage of their careers.

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[90] Mike Safe, 'Triumph by Adelaide Research Team. They've Broken the Pain Barrier. Doctors Find Key to Post-Operation Relief', *Advertiser*, 9 November 1978, 8–9, Laurence Mather Private Collection.

[91] 'Aust. Advance in War Against Pain', *Sydney Morning Herald*, 9 November 1978, 1–2, Laurence Mather Private Collection.

[92] Mike Safe, 'Researchers Break the Pain Barrier', *Daily Mirror*, 8 November 1978, 40, Laurence Mather Private Collection.

[93] L. Mather to GKD, personal communication, 23 September 2023.

Nonetheless, Bonica, who courted journalists with vigour,[94] was ecstatic, celebrating the news. Cousins shared his elation, expecting the exposure to attract research funding. The following day, Roger Russell, Flinders University's vice-chancellor, wrote a letter commending Mather, Austin and Stapleton for their 'outstanding' research. Perhaps Russell sensed Mather's embarrassment about the headlines because he added: 'The public has a right to know about important contributions being made by the institutions it supports. You brought them into the picture in a manner which was accurate and not exaggerated.'[95]

An even bigger surprise awaited Mather in his pigeonhole that day. On Parliament of South Australia letterhead, the president of the Legislative Council, Arthur Whtye, complimented him. 'My hearty congratulations on the reported breakthrough in pain research', he wrote. 'Yours sounds to be a major breakthrough in medical technique.'[96]

A few weeks later, Cousins's hopes were realised when he and Mather's applications for funding from Astra and Glaxo Pharmaceuticals were successful: Astra provided a project grant-in-aid of $15,000 and Glaxo Pharmaceuticals provided $64,000, worth $300,000 today, for studies of intravenous anaesthetic agents. The following year, Mather received a $50,000 NHMRC grant, now worth $240,000, to continue investigations. From then on, the grants his team attracted increased year by year.[97] To secure them, however, Mather and Cousins spent countless hours writing tedious applications to funding bodies, a task they and their families loathed because it usually occurred late at night, on weekends and during long-awaited family holidays.

The day after the flurry of media coverage about the pethidine research, Cousins and Bonica addressed an audience of anaesthetists at a conference titled 'Current Controversies in Obstetric Anaesthesia and Analgesia' at the Royal Women's Hospital in Melbourne.[98] That evening, Cousins returned to Adelaide and Bonica remained in Melbourne because the next day, a

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[94] JJB, Scrapbook, Box 25, Folder 7, Bonica Papers.

[95] Roger Russell to L. Mather, 10 November 1978, Laurence Mather Private Collection.

[96] Arthur Whyte to L. Mather, 10 November 1978. Laurence Mather Private Collection.

[97] Mather, 'Stereopharmacological Research in Anaesthesiology', 22–23.

[98] Lilley to JJB, 15 August 1978.

Saturday, he was due at La Trobe University for lunch with Peck and a group of pain researchers and clinicians.[99]

One week later, Bonica presented lectures to 250 anaesthetists in Sydney on the physiology of pain and the planning and evaluation of pain clinics for the Faculty of Anaesthetists. Brian Dwyer, Cousins and Glynn also presented lectures.[100] Once Bonica returned to Seattle, he wrote to Cousins:

> I want to express my pleasure and great appreciation for the opportunity of visiting your department [in] the early part of November. I was very much impressed by what you have already accomplished in the development of your department, which I now consider the foremost in Australia, and predict it will be among the top in the world in the not-too-distant future.[101]

At the beginning of December 1978, La Trobe University hosted the 'First Australia–New Zealand Conference on Pain'. It was truly multidisciplinary, with anaesthetists, surgeons, nurses, neurosurgeons, psychologists, psychiatrists, social workers, pharmacologists, physiologists and neurologists presenting forty-seven papers. Wilson presented two papers,[102] though no-one else from Flinders attended the conference. Peck suggested the reason for Cousins's absence was that he was 'not happy that we were having a conference before his planned conference, but, of course, he did not say that'.[103]

At the end of the conference, George Singer explained to the delegates that although the La Trobe team had organised the meeting with the hope of bringing the pain community together, Cousins had already 'laid the groundwork' for IASP's Australasian Chapter; by then, the chapter had been a legal entity for threemonths. Singer encouraged the delegates to attend the Australasian Chapter's first Annual Scientific Meeting the following year.[104]

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[99] JJB to C. Peck, 6 October 1978, Box 25, Folder 27, Bonica Papers.

[100] Tom Shakespeare to JJB, 13 June 1978, Box 25, Folder 27, Bonica Papers; JJB to T. Shakespeare, 11 July 1978, Box 25, Folder 27, Bonica Papers; Michael Millar to JJB, 27 April 1978, Box 25, Folder 26, Bonica Papers.

[101] JJB to MJC, 3 January 1979, Box 25, Folder 27, Bonica Papers.

[102] Connie Peck and Meredith Wallace, *Problems in Pain: Proceedings of the First Australia-New Zealand Conference on Pain* (Michigan: University of Michigan, 1980), vi, Connie Peck Private Collection.

[103] C. Peck to GKD, personal communication, 29 August 2023.

[104] C. Peck to GKD, personal communication, 29 August 2023.

In the December 1978 conference proceedings, Peck referred to Cousins's efforts to set up IASP's Australasian Chapter as a 'parallel effort'.[105] This terminology was repeated in her Distinguished Member Award by the Australian Pain Society.[106] Yet, the reality is that Cousins initiated this project in 1976, one year before Peck came to Australia. IASP's Council tentatively approved the chapter in 1977,[107] ratifying it at the Montreal Council meeting on 27 August 1978,[108] three months before the La Trobe conference.

Later in December, Glynn invited eleven colleagues from each capital city of Australia and one from New Zealand—anaesthetists, psychiatrists, neurosurgeons and pharmacologists—to serve on an interim committee. All were male and influential in pain medicine. Five of them were anaesthetists, reflecting the dominance of anaesthetists among IASP's membership and their pioneering role in establishing pain clinics.[109] Glynn had invited the pioneering pain specialist Tess Cramond (née Brophy) to join the committee, but she declined the offer,[110] possibly because Queensland University had just appointed her as a professor of anaesthetics and a member of its Senate.[111] These positions were in addition to her role as director of Royal Brisbane Hospital's Multidisciplinary Pain Centre, which she had established eleven years earlier.

In 1972, three years after the esteemed American anaesthesiologist Emanuel Papper had noted the apparent equality of status of female anaesthetists in Australia and New Zealand, a development he labelled 'unique', Cramond investigated his claim. By studying the archives of the Australian and New Zealand College of Anaesthetists (ANZCA), she discovered that female anaesthetists of exceptional ability had achieved equality through 'executive participation and senior academic positions'.[112]

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[105] Peck and Wallace, *Problems in Pain*, iv.

[106] Australian Pain Society, '2009 Distinguished Member Awards', Connie Peck.

[107] JJB to MJC, 7 November 1977, Box 2, Folder 29, Bonica Papers.

[108] Fink, Minutes: IASP Council Meeting, Montreal.

[109] Godden, *Australian Pain Society*, 35. See also, Colin S. Goodchild and Milton Cohen, 'The Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists', *Pain Medicine* 6, no. 4 (2005): 275–76.

[110] Godden, *Australian Pain Society*, 35.

[111] Geoffrey Kaye Museum of the Australian and New Zealand College of Anaesthetists, *The Rare Privilege of Medicine: Women Anaesthetists in Australia and New Zealand*, online exhibition, accessed 13 August 2024, https://geoffreykayemuseum.org.au/rareprivilege/.

[112] Geoffrey Kaye Museum, *The Rare Privilege of Medicine*.

Back at Flinders, Cousins continued his battle to fund pain research and the delivery of pain management services. His struggle was not unique to the anaesthesia department. In 1978, the South Australian Government applied funding cuts of between two and three percent across all hospitals in the state. FMC fared slightly better than most hospitals because the government kept its funding at a 'standstill figure'.[113] Despite this temporary reprieve, FMC's administrators and department heads were under intense pressure from the state's health minister to reduce operating costs.[114]

In late 1977, FMC's third phase of construction had been completed, adding extra wards for inpatients. Unfortunately, a $2 million funding shortfall and a strict freeze on staff recruitment resulted in only 360 of the 510 beds being opened to patients. The earliest these beds could be opened would be, at best, two years later, when a state election was due, and funding increases were envisaged in the lead-up to the campaign launch.

Funding was so constrained that Phase Four, the final building phase, was also postponed indefinitely, reducing FMC's bed capacity and delaying the establishment of several critical departments, such as ophthalmology and haematology. Accommodation was so limited that the Space Allocation Committee considered offering the professor of ophthalmology the staff tearoom as his office.[115]

Shortage of space also meant that, as the number of anaesthetists grew to meet the demand for surgery, they were crammed into the small anaesthesia department.[116] Responding to complaints about overcrowding, Cousins requested additional offices for them, an application the Space Allocation Committee abruptly rebuffed, noting that Cousins himself should 'give

[113] Norman Popplewell to K. J. Hancock, 14 August 1978, Box 11, Folder 7, Fraenkel Collection.

[114] FMC, 'A Report of the Flinders Medical Centre April 1976 to 30 June 1979', 3.

[115] G. F., 'Notes of a Meeting Between B. Shea, G. Fraenkel and A.W. Rogers in the Office of the Chairman of the Health Commission on 24 July 1978', Board of Management Constitution, FMC, Fraenkel Collection, 2; Norman Popplewell to K. J. Hancock, 14 August 1978, Box 11, Folder 7, Fraenkel Collection.

[116] In 1979, the anaesthesia department employed seven full-time and eight visiting anaesthetists to provide anaesthesia to 9,500 surgical patients. The number of operations increased from 627 in 1976 to 9,576 in 1979. Most of the staff specialists were employed by FMC; however, some were employed by FU. FMC, 'A Report of the Flinders Medical Centre April 1976 to 30 June 1979', 39; FMC Programmes, 'Services, Statistics and General Objectives Information', September 1979, Box 10, Folder 9, Fraenkel Collection, 8; FMC Administrator, 'Statistics Inpatient Services 3.1.1', 1979, Box 15, Folder 3, Fraenkel Collection.

consideration to re-organising the existing department with a view to making additional office space available'.[117]

By 1979, much to Cousins's annoyance, the hospital still lacked a standalone day surgery unit for patients undergoing routine surgical procedures such as varicose vein removal. While surgeons conducted day surgery in the main operating theatres, patients returned to temporary accommodation—two disused flats on the hospital campus—after surgery.[118] Cousins argued that this situation compromised patient safety, especially if surging demand for elective surgery continued at its current level or accelerated, which was highly likely based on the hospital's forecasts.[119] Determined to resolve this issue, he campaigned vigorously for construction of a day surgery unit. One of his undeclared motives was securing a dedicated space for pain management procedures such as epidural injections.

Despite the hospital's funding woes, the 'pain unit' held outpatient clinics two days each week staffed by a pain specialist from the anaesthesia department and a 'cobbled together' multidisciplinary team of Cousins's sympathetic colleagues who volunteered their time. In 1979, this team provided 1,255 outpatients with pain management services, a tenfold increase since the hospital opened.[120]

Cousins also established an inpatient pain consultation service for postoperative pain and the 'full range of chronic pain syndromes', including neuralgia, musculoskeletal, cancer and cardiac pain. In 1979, the pain team treated 500 inpatients, performing major diagnostic and therapeutic procedures such as epidural injections for chronic back pain. Through Cousins's vigorous fundraising efforts, he attracted sufficient grants from government agencies and the private sector to fund research studies on intravenous sedation, spinal pain mechanisms, analgesic responses in children and neural blockade in pain management and surgery.[121]

When Kathie Knights joined Flinders as a research assistant in 1979, the anaesthesia laboratories were well established. She worked alongside Cousins on his halothane toxicity

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[117] L. J. Barrett, 'Minutes of Space Allocation Committee', 10 July 1979, Fraenkel Collection, 3.

[118] FMC, 'A Report of the Flinders Medical Centre April 1976 to 30 June 1979', 30.

[119] FMC Programmes, 'Services, Statistics and General Objectives Information', 11.

[120] The team of 'sympathetic volunteers' included a general physician, psychiatrist, physiotherapist, clinical psychologist, social worker, neurologist, neurosurgeon and orthopaedic surgeon. FMC, 'A Report of the Flinders Medical Centre April 1976 to 30 June 1979', 30.

[121] FMC, 'A Report of the Flinders Medical Centre April 1976 to 30 June 1979', 30.

research and soon commenced a doctorate. Knights fast-tracked her doctoral studies, arriving at FMC before dawn and remaining until ten o'clock at night. She found Cousins's management style refreshing. 'It was not unusual for Michael to pop into our lab at six o'clock in the morning on his way to the operating theatre and ask: "Where are you at?"' Knights recalled he would quickly review her plans, suggest minor adjustments, then say: 'Yes, that's fine. Go right ahead.' She appreciated the scientific rigour and intellectual freedom he encouraged in her. 'If I had a problem', she recounted, 'he expected me to have exhausted every option for solving it before I sought his advice. However, if I hadn't figured it out, he was more than happy to assist me in finding a solution.'

Afternoons at Flinders were often frenzied because Cousins tried to complete everything on his ever-growing 'to-do list' before sprinting out the door. He was regularly on call at the hospital at night, believing as department head that he had an obligation to share the workload, though colleagues occasionally observed him asking senior registrars to stand in for him.[122] While he sometimes attended meetings at night, he usually tried to avoid them, as he was committed to sharing dinner with Michele and his children. Nevertheless, Michele admitted he was often late arriving home, so she kept his meal warm on a plate over a pot of simmering water on the stove—fulfilling her mother's friend's prediction before the couple married.

Most nights at bedtime, Cousins invented magical tales for his children about the adventures of a rubber horse who 'flew all over the place'; his children still remember the stories with nostalgia.[123] After tucking James, Richard and Jonathan into bed and kissing them good night, he either returned to his office at the hospital[124] or headed to Highfield's basement study for a few hours of research and writing. Michele usually joined him in the study because she was copyediting the textbook on pain and regional anaesthesia he was co-editing with Bridenbaugh.[125]

Highfield soon became a hub for Cousins's international and local pain medicine colleagues. He and Michele often invited overseas colleagues, including Bonica, Melzack and Wall, to stay at Highfield. A stream of associates also joined the family for home-cooked dinners—usually

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122 Peter Brownridge, interview by GKD, 16 November 2023.

123 Chris Cousins, interview by GKD, 25 May 2020; Jane Cousins, interview by GKD, 6 May 2020.

124 Knights, interview by GKD, 19 September 2019.

125 Michele Cousins, interview by GKD, 3 July 2019.

roast lamb or chicken. Cousins had a habit of inviting dinner guests late in the afternoon without giving Michele much notice. She, however, said it did not bother her because she was adept at quickly rustling up a superb meal. 'I always kept supplies in the pantry "to whip up" a chocolate mousse or crème caramel', she said. 'I loved entertaining Mike's colleagues because I'd always appreciated being invited to their homes when we lived overseas with a small baby. I wanted to repay the favour.'[126]

Cousins sincerely appreciated the way Michele devoted herself to running their enormous home, taking primary responsibility for raising their children, and entertaining his colleagues to help him build his professional networks; she recalled he often thanked her. Michele revelled in the opportunity to meet talented researchers from across the globe who, like Cousins, were striving to break through the pain barrier.[127] While she knew the road ahead would be rocky, she underestimated the magnitude of these challenges. So did her husband.

[126] Michele would pre-cook dishes and store them in the freezer for 'emergencies'. 'So if Mike said, "Oh gee, we should have so and so for a meal", I could pull out first, second and third courses in an instant.' Michele Cousins, interview by GKD, 23 August 2019.

[127] Michele Cousins, interview by GKD, 23 August 2019.

Chapter Six: The Race to Advance Spinal Pain Relief

Inspired by the analgesia research of Tony Yaksh and his team at the Mayo Clinic in the United States, the investigators at Flinders Medical Centre (FMC) began a series of studies on epidural pain relief in the late 1970s. The Mayo scientists found that injecting morphine into the intrathecal space—the fluid-filled area between the innermost layer covering the spinal cord and the middle layer[1]—relieved pain.[2] In 1977, the anaesthetist Peter Wilson joined FMC from the Mayo Clinic, where he had worked alongside Yaksh. Soon after arriving at Flinders, he received one of the hospital's first research foundation awards for his project: 'Selective spinal analgesia by epidural administration of narcotics.'[3]

In a break from the standard practice, FMC's researchers injected pethidine rather than morphine into the epidural space.[i] Mather postulated that using pethidine instead of morphine might capitalise on the local anaesthetic action of pethidine to heighten its pain-relieving activity in the spinal cord. He thought any systemic effects of the larger dose used epidurally might augment any spinal action.[4]

The first patient they tested with this technique was a fifty-five-year-old woman named Dora who suffered from severe upper back pain following colon surgery. Early one evening, Dora lay on a bed in the recovery ward, a six-member research team having prepared her to receive an epidural injection of pethidine. Constantly wriggling to relieve her pain, she rated it as ten on a scale of one to ten. Two nurses scurried around tidying up before leaving for the day, while Mather stood beside Dora's right shoulder chatting with her about the procedure.

Mather taped a thermometer around Dora's right big toe to measure any changes in her body temperature triggered by pethidine's local anaesthetic action. Then Cousins injected the analgesic via a catheter leading into the epidural space in her upper back. After observing Dora's facial expressions and body language for twenty minutes, he asked: 'How's your pain?'

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[1] Harris, Nagy and Vardaxis, *Mosby's Dictionary of Medicine*, 923.

[2] Tony Yaksh and Thomas Rudy, 'Analgesia Mediated by a Direct Spinal Action of Narcotics', *Science*, 192, no. 4246 (June 1976): 1357–58.

[3] MJC, 'Minutes of the Thirteenth Meeting of the Division of Anaesthesia and Intensive Care, 13 June 1979', Box 15, Folder 3, Fraenkel Collection, 4.

[4] Mather, 'Stereopharmacological Research in Anaesthesiology', 32.

‘I don’t have any pain’, she said.

‘Do your legs feel numb?’

‘No. They feel normal.’

He instructed Dora to wiggle her legs. She did.

This response astounded the team members because the pethidine had not caused the loss of feeling or movement in the legs that occurred whenever they injected a local anaesthetic into a patient’s epidural space. They postulated that the initial pain relief from high doses of epidural pethidine resulted from an analgesic action in the spinal cord.[5]

During the following weeks, the Flinders investigators repeated the procedure on fifteen more patients, seven with postoperative pain and eight with intractable pain. In all patients, the onset of pain relief occurred within five minutes and was complete within thirty minutes. The researchers were ecstatic, realising an improved method of pain relief was seemingly within grasp.[6]

They immediately wrote a report describing the procedure and patient responses, suggesting pain relief administered through the epidural space raised the possibility of ‘selective spinal analgesia’, because injecting opioids avoided the loss of sensation and movement that usually accompanied the epidural administration of local anaesthetic. The following day, 24 April 1979, they faxed the report to the prestigious British medical journal the *Lancet*. The journal’s editor published the report one month later.[7] It was the third-ever clinical report on the topic.[8] Cousins also posted a copy of the report to Bonica.[9] Two years later, the journal *Anesthesiology* published a detailed description of the study.[10] It was a triumph, thrusting Cousins and the FMC group into the spotlight.

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[5] Chris Glynn et al., ‘Peridural Meperidine in Humans: Analgetic Response, Pharmacokinetics, and Transmission into CSF’, *Survey of Anesthesiology* 26, no. 5 (1982): 520; Mather, interview by GKD, 14 April 2019.

[6] Mather, interview by GKD, 14 April 2019.

[7] Michael Cousins et al., ‘Selective Spinal Analgesia’, *Lancet (British edition)* 1, no. 8126 (1979): 1141–42.

[8] Mather, ‘Stereopharmacological Research in Anaesthesiology’, 32.

[9] MJC to JJB, 24 April 1979, Box 2, Folder 29, Bonica Papers.

[10] Glynn et al., ‘Peridural Meperidine in Humans’, 520–26.

This concept stimulated intense excitement around the world among researchers who were feverishly trying to find the most effective ways of delivering pain-relieving drugs via the epidural space. 'There was a bit of a race on between different research groups to be the first to publish new methods of spinal pain relief', Cousins recalled forty years later. 'I think it happens every time something new and exciting appears on the horizon.' It was an exhilarating time to be researching epidural pain relief. 'Our team became euphoric', he beamed, adding that, at first, they asked: 'Can it be true?' Then they became convinced it was right. 'Part of the reward of research is publishing and communicating the findings. It's a signal you've contributed to better understanding an illness, and it eggs you on to do more to see if you can improve the way we treat medical conditions.'

Two months later, the FMC researchers conducted a clinical study with cancer patients undergoing chest surgery. They injected morphine into the patients' epidural space during the operation and found the pain relief continued for several days after the surgery. This discovery thrilled them; however, to their dismay, they noticed the breathing of two patients slowed and became shallow several hours after they had returned to the hospital ward. Again, they wrote to the *Lancet* outlining their findings. The editor published the letter a few days later.[11] It was the first report of delayed depression of breathing associated with the injection of morphine into the epidural space.[ii]

The epidural analgesia studies catapulted FMC's scientists onto the world stage in pain medicine research.[iii] Three years after the *Lancet* letters appeared, the American journal *Anesthesiology* invited Cousins and Mather to co-author a comprehensive review of the science of spinal opioids.[12] This review is still viewed as seminal in the field of epidural anaesthesia and analgesia.[13]

As planned, IASP's Australasian Chapter hosted its first Annual Scientific Meeting, which Cousins chaired, on 18 May 1979.[iv] To his amazement, it attracted 120 delegates.[14] One of his goals in arranging an integrated meeting with anaesthetists and surgeons was to improve

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[11] Chris Glynn et al., 'Spinal Narcotics and Respiratory Depression', *Lancet* 2, no. 8138 (18 August 1979): 356–57.

[12] Michael Cousins and Laurence Mather, 'Intrathecal and Epidural Administration of Opioids', *Anesthesiology* 61 (1984): 276–310.

[13] Ted Shipton, 'Honouring a Giant in the Field of Pain Medicine. A Pain Medicine Perspective', *ANZCA Bulletin* (December 2016): 80–83.

[14] Godden, *Australian Pain Society*, 36.

communication between them and researchers to reduce the time it took for clinicians to adopt new treatments based on the results of the latest scientific studies, one of Bonica's principal goals in establishing IASP.[15] At the meeting, local and international pain experts, all men, shared research findings in this rapidly growing field of medicine. Glynn and Cousins presented the results of the selective spinal analgesia studies they had completed three weeks earlier.[16]

Bruce Rounsefell, who headed Royal Adelaide Hospital's Pain Management Unit for twenty-five years, attended the meeting and was astonished to meet so many physicians treating people suffering from pain. 'It was a bit of a worldwide mini-explosion of sudden interest in pain', he recalled. 'The mood in the room was electric, and everyone felt euphoric.'[17]

Tony Yaksh, who had shaggy hair, a bushy beard, moustache and wore tinted glasses, was a keynote speaker. Someone who spoke 'English faster than anyone else we knew', according to Jones,[18] Yaksh thrilled the audience when he spoke about the use of local anaesthesia to block pain sensations in particular areas of the body. Capturing the exhilaration and optimism in pain medicine at the time, Yaksh said everyone in the pain world thought the ability to manage pain was close at hand.[19] Disappointingly, later research revealed pain was far more complicated than anyone had imagined in those heady days.

Peck recalled that Cousins praised her for the excellence of the La Trobe conference in his speech at the formal dinner. 'I was quite pleased with this', Peck wrote in 2023, 'because I took it as a sign we had successfully navigated the problem with the two parallel ideas of bringing pain professionals together to start a new pain society'.[20] A few years later, Cousins offered Peck a role as a clinical psychologist at FMC; however, she declined because she and her husband had just finished building a house they loved in Melbourne.

Late at night and on weekends, Cousins continued to edit the neural blockade textbook with Bridenbaugh, who visited Adelaide a few times so they could collaborate more closely.

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[15] Jones, *First Steps*, 1–2.

[16] Chris Glynn et al., 'Conference Abstract: Selective Spinal Analgesia in Man following Epidural Administration of Pethidine', *Anaesthesia and Intensive Care* 8 (August 1980): 371.

[17] Bruce Rounsefell, interview by GKD, 11 November 2019.

[18] Jones, *First Steps*, 21.

[19] Godden, *Australian Pain Society*, 36.

[20] Peck to GKD, personal communication, 29 August 2023.

Ensuring the thirty-nine contributors submitted their chapters on time was a 'monumental challenge', according to Cousins, who admitted it took a mountain of 'tact, encouragement and pushing' because each author was a leader in regional anaesthesia and extremely busy. Nevertheless, he said it was often worth the wait because the 'latest ones were those most worth waiting for'.

In late 1979, shortly before Cousins's fortieth birthday, he and Bridenbaugh finished the manuscript and J. B. Lippincott & Co. published *Neural Blockade in Clinical Anesthesia and Management of Pain* in 1980.[21] It was the first comprehensive modern textbook on regional anaesthesia and pain and included chapters on the basic pharmacology and physiology of neural blockade, clinical techniques and their use in pain management.

Cousins wrote chapters on local anaesthesia and epidural and sympathetic neural blockade, and Mather, with his former colleague from Bonica's laboratory, Geoff Tucker, co-wrote a chapter on the pharmacokinetics of local anaesthetics. Wilson, by then a senior lecturer and senior specialist in the Flinders pain unit, contributed a chapter entitled 'Neurologic Mechanisms of Pain: Modifications by Neural Blockade', and Glynn, clinical coordinator of FMC's pain unit, collaborated with Cousins on the closing chapter, 'New Horizons'. The obstetric anaesthetist, Peter Brownridge, who joined FMC from Birmingham in 1979, wrote a chapter on gynaecological and obstetric anaesthesia and pain relief. Four other Australians authored chapters: Brian Dwyer, David Gibb, F. R. Berry and Kevin McCaul. International anaesthetists and pain specialists drafted the remaining chapters.

In the foreword, Oxford University's emeritus professor of anaesthesia Sir Robert Macintosh wrote:

> *Neural Blockade in Clinical Anesthesia and Management of Pain* must be the most ambitious project of its kind ever undertaken. The book is indeed encyclopedic in its coverage and like encyclopedias in other sciences, each section has been entrusted to a recognized world authority in his own special field.[22]

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[21] Michael Cousins and Phillip Bridenbaugh, eds., *Neural Blockade in Clinical Anesthesia and Management of Pain* (Philadelphia: J. B. Lippincott Company, 1980).

[22] Robert Macintosh, 'Foreword', in *Neural Blockade in Clinical Anesthesia and Management of Pain*, ed. Michael Cousins and Phillip Bridenbaugh (Philadelphia: J.B. Lippincott Company, 1980), ix.

The all-male cast of contributors reflected the continued dominance of men in medicine in the 1980s despite the rise of feminism in the 1970s. The lack of female contributors might also indicate the composition of Cousins's and Bridenbaugh's cloistered professional networks.

Reviews of *Neural Blockade* were overwhelmingly positive. In the *New England Journal of Medicine*, the highly respected anaesthesiologist Michael Stanton-Hicks wrote: 'The book is a landmark in regional anesthesia.'[23] The journal *Anesthesia and Analgesia* published a review by Harvard professor Benjamin Covino, who congratulated the editors for assembling the pain world's leaders as contributors who combined the basic science of local anaesthesia with clinical details of regional anaesthesia and analgesia.[24]

Publication of *Neural Blockade* triggered an avalanche of invitations for Cousins to deliver orations internationally and write chapters for textbooks. 'Michael was a remarkably logical speaker and author, preparing speeches and research material very, very clearly', Peter Brownridge observed. 'It was his clarity that appealed to me. He was always really very confident in what he was saying. He was also charismatic and charming.'[25] During the next five years, Cousins would present sixteen keynote addresses overseas, co-author thirty-three journal articles and publish eleven book chapters.[26] It heralded his arrival into the higher echelons of the nascent pain world.

In 1982, in recognition of his research excellence, the Royal Australasian College of Surgeons awarded him the prestigious John Mitchell Crouch Award.[v] In a 2019 interview, Cousins said that while he felt proud to receive the award, he believed it belonged to the entire FMC team rather than to him alone.[27] Perhaps this remark, made forty years after receiving the award, reflected his recognition that it had contributed to festering jealousies within FMC's anaesthesia department?

One consequence of Cousins's rising status was that anaesthetists from the United Kingdom, Canada and America flocked to FMC to further their training as anaesthesia, intensive care and

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[23] Michael Stanton-Hicks, 'Book Review', *New England Journal of Medicine* 304, no. 24 (1981): 1497–98.

[24] Benjamin Colvino, 'Review of *Neural Blockade in Clinical Anesthesia and Management of Pain*, eds. Michael Cousins and Phillip Bridenbaugh'. *Anesthesia and Analgesia* 60, no. 4 (April 1981): 232.

[25] Brownridge, interview.

[26] MJC, 'Curriculum Vitae: Professor Michael Cousins AO', 2016, 14–41; Russo, 'The Michael J. Cousins Lifetime Achievement Award'.

[27] MJC, interview by GKD, 1 May 2019.

pain medicine fellows. The calibre of the fellows who visited Flinders impressed David Cherry, who joined FMC as a clinical lecturer in 1980 and later headed the pain unit. 'Normally, I criticise Michael Cousins', he stated. 'However, he did attract some very, very intelligent people to Flinders.'[28] Those visitors were the first in a succession of pain medicine fellows Cousins would train during the next thirty-five years. Knights noted how Cousins mentored the fellows, as he did her and countless other postgraduate students and colleagues.

'As a mentor, Michael was amazing', Knights stated, 'in that you could ask him anything you wanted to know, and he'd always give you a straight answer. Even if he disagreed with your decision, he'd support you. Doing my PhD with Michael gave me the foundations for the intellectual rigour of my future career.' Several pain medicine fellows and PhD students made similar remarks, acknowledging Cousins for his creative ideas for research, 'boundless enthusiasm', moral support and unwavering commitment to them and their careers.[29]

Overwhelmed by the sudden escalation of demands on his time, Cousins coped by making a point of allocating two days to a project if he decided it was a priority. 'Because you won't get that time again, and it might decide yes or no for you.' He often counselled his colleagues: 'Try not to take on more than you can reasonably handle', yet he routinely disobeyed his own advice.

Harris, who suggested that Cousins 'sometimes didn't know when he needed to take a rest', was in awe of the number of activities his mentor squeezed into every day:

> Quite often I'd see him in the morning, and he'd been at the hospital since before dawn for an early emergency call to see a patient and then by eight o'clock, he was addressing a group of doctors. Then he'd come into the office and deal with one or two matters before going to more meetings. So, he'd already done a full day's work by midday. Despite his heavy workload, his demeanour was one of openness and calmness.

When a team member approached Cousins with a problem, his typical response, according to Harris, was: 'What's the issue?', 'What do you want me to do?', 'Okay, I'm glad I can do "a" and "b", but please don't ask me to do "c".' Harris said Cousins had the 'brain power' necessary

[28] David Cherry, interview by GKD, 19 August 2022.

[29] Lea Thin Seow, 'Intravenous and Regional Anaesthesia Techniques: Drug Effect and Pharmacokinetic Studies' (PhD thesis, FU, 1983); Kevin Austin, 'Pharmacokinetic and Pharmacodynamic Studies of Selected Therapeutic Agents' (PhD thesis, FU, 1980); Bill Runciman, 'The Effects of General and Spinal Anaesthesia on Regional Blood Flow and Drug Disposition in the Sheep' (PhD thesis, FU, 1982).

to solve an issue quickly and move on and that his colleagues respected this ability, seeking his counsel because they trusted his judgement.[30]

Shortly after the publication of *Neural Blockade*, Cousins flew to Lisbon to attend his first IASP Council meeting. Bonica was in hospital for two months undergoing another of his many hip operations, so he could not attend the meeting. Instead, he circulated a comprehensive president's report to council members before the meeting and briefed Ray Fink, director of research at the University of Washington's Anesthesia Research Center and the meeting's chair, on his views on each agenda item.[31] 'Everything John proposed went through', Cousins said in an oral history interview seventeen years later. 'One of the council members quipped: "He's not here, but by George, you can see the influence he has." John Bonica dictated responses to virtually every item on the agenda.'[32]

Cousins recalled feeling like a 'neophyte among a group of giants' at the meeting, especially when it was his turn to speak. Despite his nerves, he enjoyed providing an update on the Australasian Chapter, which by then included members from Australia, New Zealand, Singapore and Kuala Lumpur.[33] He found it exhilarating to mix with the other IASP Council members. 'They were all first-rate pain researchers, so I heard firsthand about their latest discoveries.'

In Lisbon, he joined the two committees Bonica considered mandatory for the future of IASP and the fledgling field of pain medicine: the Ad Hoc Committee on Research and Ethical Issues and the Subcommittee on Taxonomy, which developed definitions of pain terms and the

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[30] Harris, interview.

[31] JJB to Ray Fink, Chair of the March 1980 IASP Council Meeting in Lisbon, 20 February 1980, Box 55, Folder 53, Bonica Papers; JJB, 'President's Report to Lisbon Council Meeting', 17 March 1980, Box 55, Folder 50, Bonica Papers.

[32] MJC, interview by M. Meldrum; Ray Fink, 'Minutes: IASP Council Meeting Lisbon', 21 March 1980, Box 55, Folder 48, Bonica Papers.

[33] Fink, Minutes: IASP Council Meeting Lisbon, 8.

classification of pain syndromes.[34] That took his committee membership to four. The other two were the Public Information Committee and the Bonica-chaired Nomination Subcommittee.[35]

After returning to Australia, Cousins wrote to Bonica, sharing highlights of the Lisbon meeting and noting his membership of the taxonomy and research committees.[36] Bonica replied,[37] praising him, though acknowledging that several IASP members believed it was impossible to agree on a system of definitions to define various pain syndromes.[vi]

Back at FMC, Knights observed an extraordinarily intense level of competition, 'even within the same room' because of the highly ambitious and often aggressive young department heads Fraenkel had recruited and the chronic scarcity of resources.[38] When asked about his own competitive streak,[39] Cousins insisted that his attitude was 'gentlemanly' and that he never took a 'winner takes all' approach. The majority of his colleagues and those close to him agree;[vii] however, Glynn, Cherry and Gourlay, disagree, claiming that he 'passed off' their ideas as his own and did not acknowledge their contributions, especially in conference papers.[40]

'What Michael said and did didn't always match what he thought he was going to do', Gourlay explained. 'He was a bit tricky', Gourlay noted, adding:

> As the senior person in our department, he viewed all the research as his. It was his team, and he owned its research. Michael did what benefited Michael and if your goals and his aligned, all well and good and you got reflective glory from him. He supported team members who shared his vision and work ethic, and he went to great lengths to source research grants for them. It was a symbiotic relationship.

Gourlay acknowledged that Cousins had 'a lot of very positive and admirable qualities'. When Gourlay disagreed with something Cousins did or said, he would confront him. 'And that, to

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[34] JJB, 'President's Report to Lisbon Council Meeting'. Bonica considered the 'development and implementation of a universally accepted taxonomy on pain was one of the most urgent and most important objectives of IASP'. See Jones, *First Steps*, 22.

[35] L. Jones, 'Proposed Committees 1979', 27 April 1979, Box 55, Folder 44, Bonica Papers. Bonica required members of the Public Information Committee to be 'active, responsive to requests and make significant contributions to our efforts'. JJB to Elie Cass, 13 October 1978, Box 4, Folder 124, Bonica Papers.

[36] MJC to JJB, 17 April 1980, Box 2, Folder 29, Bonica Papers.

[37] JJB to MJC, 9 June 1980, Box 55, Folder 53, Bonica Papers.

[38] Kathie Knights, interview by GKD, 28 August 2023.

[39] MJC, interview by GKD, 7 July 2019.

[40] Glynn, interview; Cherry, interview; Gourlay, interview.

be honest, didn't happen a lot', he stated. 'It could have happened a lot, but it didn't. On the occasions it did, he would take it on the chin, and we'd move on.'[41]

In a December 2022 interview, Glynn claimed that Cousins had placed himself as the first author of a seminal journal article (published in the 1980s) that Cousins had promised to him. Four decades later, Glynn still held this grudge and his remarks about Cousins were venomous.[42] Equally disparaging was Cherry, who alleged that Cousins was the first author on papers when he had not led the research study, written the paper or made a significant contribution other than securing financial support.[43] This is a common source of conflict within academia and a vexed issue because of the group nature of scientific research, fierce competition for recognition in academic circles and the centrality of publications in gaining promotion to senior positions.[44]

Mather, Knights and even Gourlay insisted they never experienced an issue with Cousins about attribution of authorship.[45] So did several former doctoral students and a multiplicity of colleagues throughout Cousins's five-decade career. 'Quite honestly, I never had any problem whatsoever with Michael about attribution of authorship or acknowledgment of my contributions', Peter Brownridge attested. Brownridge particularly appreciated Cousins's unwavering support in the face of opposition from other anaesthetists who resented his exclusive focus on obstetric anaesthesia rather than sharing their workload in the operating theatres. 'Michael was very kind and generous to me personally and helped to promote my career both nationally and internationally. I was very privileged to have worked with him.'[46]

The greater majority of Cousins's colleagues claimed he championed their contributions, encouraging them to identify as the chief investigator and first author. A common theme of their remarks was that he tirelessly applied for competitive research grants and funding from the private sector, foundations and other sources for their projects. It often surprised them when

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[41] Gourlay, interview.

[42] Glynn, interview.

[43] Cherry, interview.

[44] Several editorials and letters in *Nature* and other science journals debated this issue. Anonymous, 'Games People Play with Authors' Names', *Nature* 387, no. 6636 (26 June 1997): 831; William F. Laurence, 'Second Thoughts on Who Goes Where in Author List', *Nature* 442, no. 7098 (6 July 2006): 26.

[45] L. Mather, interview by GKD, 21 March 2023; Knights, interview by GKD, 28 August 2023; Gourlay, interview.

[46] Brownridge, interview.

he succeeded despite severe funding constraints, almost like a magician pulling a rabbit out of a hat. He also nurtured them and their research, created rosters that gave them sufficient time to conduct studies, and provided 'infectious commitment, dedication and limitless energy'.[47]

When asked for his perspective on complaints about attribution, Cousins insisted his 'policy' was to encourage younger researchers to be the first author to help build their research profile and reputation, an approach he had learned from Bonica. An analysis of the publications in which Cousins was credited revealed that of the seventy-four journal articles the FMC team published over a fifteen-year period, he was listed as the first author eight times. In the remaining sixty-six papers, his most frequent position was as the last author, though it varied according to the extent of his involvement in each study.[48]

Mather explained that, in most scientific laboratories, the director spends much of their time applying for grants to pay the salaries of research staff and buy all the equipment required to conduct studies. They also supervise staff, teach medical students, negotiate for resources, navigate organisational politics to protect their department and its resource base, complete myriad administrative duties, present research papers at conferences and participate in professional organisations. In a hospital setting, they also treat patients, as was the case with Cousins. Usually, the director appoints early career researchers, and, if funding permits, more senior people, to conduct studies under varying levels of supervision. 'That was certainly the John Bonica model at the University of Washington and one Michael implemented at Flinders',[49] Mather stated.

'The important point', Mather emphasised:

> is that Michael's innovation was to secure endless research grants for the postgraduate students and scientists in a bleak financial environment and nurture a culture where scientists and clinicians collaborated on studies. Michael was determined to make HIS department prominent, both nationally and internationally, just like the Bonica model.

[47] Austin, 'Pharmacokinetic and Pharmacodynamic Studies of Selected Therapeutic Agents'.

[48] MJC, 'Curriculum Vitae: Professor Michael Cousins AO', 2016, 20–25.

[49] L. Mather to GKD, personal communication, 11 December 2022.

Mather believed strong egos and personal ambitions within the anaesthesia department festered resentments and some individuals believed they deserved more of the accolades Cousins received.[50]

Figure 12: Michael Cousins's Laboratory at Flinders Medical Centre, late 1980s.

Courtesy Laurence Mather.

O'Grady and Brownridge agreed with Mather's summation of the simmering tensions, suggesting professional jealousy and 'tall poppy syndrome' drove the bitterness of some colleagues towards Cousins.[51] Brownridge also believed a driving factor was Cousins's relative youthfulness as a full professor and department head. 'Everyone in the department was young and at the beginning of their ascent', he recalled. 'A senior, much older figure, which is the usual practice for department heads, would not have attracted so much hostility. Everyone in the team was young and ambitious and intent on advancing their careers.'[52]

O'Grady added that some of Cousins's colleagues were envious that he had had the advantage of being mentored by Melzack, Wall and Bonica. 'His critics didn't have this background and resented it', she said. 'Their feathers were ruffled. Bright blokes, they had high egos. Goodness me. How could he protect the egos of those blokes?'[53]

Brownridge, who surmised that broken promises were a source of conflict within the department, insisted that Cousins always kept his commitments to him despite fierce opposition from the other anaesthetists. Still, he observed two instances of broken promises that rankled

[50] L. Mather to GKD, personal communication, 11 December 2022.

[51] O'Grady, interview; Brownridge, interview.

[52] Brownridge, interview.

[53] O'Grady, interview.

his colleagues. One of them was assurances of promotion that were not honoured. The other occurred when Cousins was deciding who to choose as the first director of the pain unit. 'The story I heard from David Cherry, Chris Glynn and Peter Wilson', Brownridge recalled, 'was that Michael might have promised each of them they would be appointed. "We'll find out in due course who gets the job", was the running joke within the department.' Glynn had expected to be appointed because he was the pain unit's clinical coordinator. When Cousins selected Cherry, an aggrieved Glynn left, returning to Oxford. And Wilson, equally incensed, returned to the Mayo Clinic.

Brownridge acknowledged the extraordinary amount of 'griping' among the FMC anaesthetists. Sometimes he heard senior consultants criticising their colleagues, which he thought was unprofessional. 'I could never put my finger on the reason for it', he said. 'Each anaesthetist was a decent fellow with an excellent brain. They all had a good reputation before joining the department, but then to become so miserable was puzzling.'[54]

Ross Harris observed this conflict and Cousins's response to it from the perspective of his psychology training. 'Michael accepted dissent with a shrug of the shoulders', Harris recounted, 'recognising sensibly that no team can exist without personality clashes and times of conflict.' Harris understood that conflict is part of the struggle for ideas in an intensely competitive environment, and he believed it was up to everyone, not just the boss, to resolve it. 'Michael put disagreements on the table and expected us all to resolve them.'[55]

Throughout the late 1970s, Cousins continued his crusade to build a dedicated day surgery unit. In mid-1980, John Cooper, a commissioner from South Australia's Health Commission, informed the hospital's administrator that planning consultants contracted to assess space requirements of the Phase Four building plans—'J' Contract—had approved the extension of facilities for primary care and community medicine. Frustratingly, the consultants withheld approval for the day surgery unit and short-stay recovery ward, which, they attested, were 'over programmed'.

To gain approval, the consultants told Cousins to redesign the facilities to fit the space allocated to them. In his report, Cooper expressed concern that the four procedure rooms and 'associated supportive facilities' Cousins had requested for the day surgery unit would require extra staff

[54] Brownridge, interview.

[55] Harris, interview.

to manage them. Unfortunately, budgetary constraints precluded the employment of more staff. The consultant recommended the construction of two procedure rooms and that Cousins resubmit plans within the prescribed space allocation,[56] setting the stage for a showdown.

One month later, at a meeting of the project planning team, of which Cousins was not a member, Fraenkel nominated Cousins to join a ten-member working party to examine the consultant's report and provide recommendations to the planning team. The following week, at its 'special' meeting, the planning team scrutinised these proposals.[57]

The meeting's first agenda item was the day surgery unit. Cousins explained that the pain unit staff had performed 964 nerve blocks in the recovery ward, the 'temporary pain management procedure area', during the previous twelve months. He insisted that this imposed 'intolerable' strains on the facilities and staff. Revealing that 100 of the inpatients could have been 'day patients' if a room was dedicated to pain management, he enticed the committee members by itemising the savings if these patients had stayed in a day surgery unit rather than overnight in an expensive hospital ward.

The other three rooms, Cousins explained, were required to accommodate current and forecast surgical workloads, adding: 'Based on an analysis of day surgery units in America, the consultants must allocate more space for day surgery.' Fraenkel, as committee chair, rebuffed him, demanding further documentation to support his claims.[58]

Exasperated, though not defeated, the character traits that would distinguish Cousins throughout his career came to the fore, especially manoeuvring around barriers with a quiet resolve. Harris admired the way Cousins dealt with roadblocks: 'Michael was very patient, but he always searched for ways to resolve issues', Harris recollected, adding that Cousins encouraged his frustrated pain centre colleagues to persevere until he had navigated a course through each obstacle.

On other occasions, however, when the authority was in his hands, Harris said that Cousins could be quite forceful: 'Well, let's not waste too much time on this because I've been there, I

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[56] John Cooper, 'FMC Phase Four 'J' Block', 14 April 1980, 1–3, Box 12, Folder 4, Fraenkel Collection.

[57] Norman Popplewell, 'Minutes Project Planning Team Meeting', 12 May 1980, Box 10, Folder 9, Fraenkel Collection, 1–2.

[58] R. Southward, 'Minutes Special Meeting of the Project Planning Team: Contract "J"', 20 May 1980, Box 10, Folder 9, Fraenkel Collection, 1–2.

know about this, and this is the way it's going to be.' If Cousins justified his reasoning, FMC's anaesthesia staff usually appreciated the breadth of his experience. 'Whenever Michael was determined to progress a particular item of business, he'd talk about his rationale for pursuing a particular course of action', Harris recalled. 'By and large, we all went along with his suggestions.'[59]

Another of Cousins's favourite tactics was inundating health bureaucrats with exhaustive lists of statistics and facts to justify his claims. In response to further questions from Cooper, he fired off a forensic, three-page analysis of the proposed day surgery unit's workload to Fraenkel. It refuted, point by point, and in painstaking detail, figures provided in the consultant's report.[60] Fraenkel sent the missive to Cooper, though it would be several months before he received a reply.

In the meantime, Cousins's life was about to reach its lowest point. In late August 1980, Michele's parents visited them for the school holidays. Michele, Poppy, Trenham and the three boys drove six hours north of Adelaide to the Flinders Ranges. They stayed at Parachilna Gorge for five days and, on the way home, fell in love with Wilpena Pound, an elliptical crown of serrated mountains with a sunken natural amphitheatre in its centre. They stopped to walk up Wilpena. Poppy and Richard said they felt unwell. Poppy remained in the car with Jonathan; however, despite feeling 'off-colour', Richard joined his mother, grandfather and James on a walk. Afterwards, they returned to Adelaide and enjoyed a quiet Sunday evening at home, unaware of what lay ahead.

The next morning, Poppy felt ill, collapsed on the bathroom floor and hit her head on the hard tiles. The gash in her head was so severe, she required stitches. Cousins drove her to FMC, where the doctors admitted her to a medical ward. Later on Wednesday morning, Richard had a fever and vomited several times. The family's general practitioner could not do a home visit, so Michele carried her son downstairs, bundled him into the back seat of the car and drove him to the doctor's surgery.

As soon as the doctor felt Richard's racing pulse, he told Michele her son was critically ill, and she should rush him to Adelaide Children's Hospital. Once there, Michele rang O'Grady, who bolted to the recovery ward where Cousins and Gourlay were conducting a postoperative pain

[59] Harris, interview.

[60] GF to John Cooper, 8 October 1980, Box 12, Folder 4, Fraenkel Collection.

study. O'Grady ushered Cousins into a quiet corner off the corridor before breaking the news to him. Ashen faced, he returned to the recovery ward. 'I've got to leave', he told Gourlay in an urgent voice. 'My son is ill in the children's hospital.'[61]

Although Richard's paediatrician 'tried every known treatment' to save him, a virus had overwhelmed his heart muscle. Tragically, eight-year-old Richard died the same day of viral myocarditis.[62]

Engulfed by grief, Cousins felt an overwhelming sense of guilt because he had been working rather than at home to care for his beloved son. Geoff Cousins flew to Adelaide as soon as he heard the news, and he helped his older brother and Michele organise Richard's funeral. Cousins was so distraught that Geoff worried he would never recover; even later in life, Cousins found it too distressing to speak about his son's passing. One thing that helped Richard's distraught parents cope with their grief was prayer, even though Cousins was not a religious person, and he did not go to church except for Easter and Christmas services.

Cousins took bereavement leave for a few weeks and cancelled a multitude of commitments. Heartbroken and desolate, his only source of solace was spending time with Michele, James and Jonathan. On his return to FMC, he was intensely withdrawn; he 'dragged himself around the hospital', no longer sprinting along the corridors and up the stairs as had been his former habit. He no longer arrived at his office at six o'clock in the morning or returned at night after dinner, and, for several months, he lacked the confidence to anaesthetise patients in the operating theatres.[63]

His immense sorrow was palpable throughout the hospital and shared by his colleagues, who longed to lift the burden from his shoulders. 'For the professor of anaesthesia and intensive care to lose his son under those conditions was devastating for us all', Gourlay recollected. 'It took a long time, understandably, most understandably, for him to reintegrate into the department. He did what he had to do, often disappearing to collect himself.' Even Cherry, who was caustic in his remarks about Cousins, gave him a 'tick' for the way he controlled his emotions. 'The whole episode was just horrendous', Cherry recalled. 'To his credit, and I'll

[61] Gourlay, interview.

[62] Viral myocarditis is inflammation of the heart caused by a virus. Harris, Nagy and Vardaxis, *Mosby's Dictionary of Medicine*, 1812.

[63] O'Grady, interview; Knights, interview by GKD, 24 October 2023.

give credit where credit's due, he did remarkably well.' O'Grady praised Michele for being an 'absolute' tower of strength. 'Eventually, with Michele's strength and deep love, Michael came through, but it took a long, long time', she said.

Nine months and two weeks after Richard's death, Michele gave birth to healthy twins she and Cousins named Jane and Christopher. They were rapturous, viewing their newborns as a special gift; they felt immensely blessed (Figure 13).

Figure 13: Two-year-old Jane and Chris Cousins at Highfield, 1983.

Photographer: David Simpson. Courtesy Michael and Michele Cousins.

Chapter Seven: Surging Interest in Pain Medicine

Interest in pain medicine soared during the 1980s. Within a year of its launch, the Australasian Chapter of IASP grew to 138 members, thirteen from New Zealand and the same number from Asia.[1] Capitalising on this growth, Cousins hosted the chapter's third scientific meeting at Flinders University.[i] Determined to keep the meeting low priced, he asked O'Grady to create the books of abstracts by photocopying and binding them by hand.[ii] John Liebeskind, a University of California, Los Angeles (UCLA) psychologist and neuroscientist, presented the first paper.

Liebeskind stood at the podium in the echoey lecture theatre checking his notes while the delegates filed in noisily. The room was alive with excited chatter, and a sense of expectation hung in the air. Cousins sat at the front of the theatre admiring Liebeskind's 'distinctive look': his hair had turned a silvery grey earlier than usual, and Cousins thought he had a 'baby face'. Liebeskind held a thick bundle of typed A4 pages. Noticing the bulkiness of the speech, Cousins dreaded an hour of listening to a presentation read from a script. 'Yet once John Liebeskind started speaking, he eloquently painted a picture of the field of pain medicine at that moment in time', Cousins reminisced. 'He entranced and inspired everyone in the room. I sat transfixed.'

Another pain medicine researcher who inspired Cousins was the neurosurgeon John Loeser. In 1982, four years after Bonica retired, the University of Washington (UW) appointed Loeser as director of its Multidisciplinary Pain Center. Disappointingly, without Bonica's force of personality and relentless advocacy, funding had 'dried up', and Loeser was determined to return the centre to its 'former glory'.[iii]

Loeser worked closely with the psychologist Bill Fordyce, Peck's former colleague. Shortly after Loeser began his new role, he and Fordyce had been overjoyed to discover an empty ward at UW's hospital. They were even more elated when the hospital administrators allowed the pair to convert the ward into facilities to treat people living with chronic pain. Using this

[1] MJC, 'IASP Newsletter: Chapter Activities', February 1980, Box 55 Folder 48, Bonica Papers; Godden, *Australian Pain Society*, 37; John-Marie Besson, 'Report of the Committee on Membership', 1 August 1981, Box 55, Folder 53, Bonica Papers.

specialist space, the two researchers created a structured three-week inpatient pain management program.

Loeser and Fordyce based the structured program on behavioural psychology, using social reinforcers to change pain behaviours, which was innovative. This biopsychosocial approach to pain management replaced the traditional biomedical model of earlier years and involved addressing the biological, psychological and social aspects of pain. For patients with chronic pain, this meant encouraging them to gradually increase their level of activity and simultaneously taper the amount of medication they used.[2]

Eager to learn more about behavioural psychology and the structured program, Cousins planned a visit to UW. He postponed this trip, however, when he received a panicked phone call from his mother, Marjorie. She told him that his father Hedley had suffered a stroke and been rushed to Royal North Shore Hospital (RNSH) by ambulance. In shock and feeling as if he was on autopilot, Cousins caught the next flight to Sydney.

Upon reaching RNSH, he hurtled up the stairs two at a time to his father's ward. Out of breath, what he saw deeply distressed him. His father's face was waxen and he could not speak, something Cousins knew would frustrate Hedley because he was such a consummate communicator. Cousins, his siblings and Marjorie kept a vigil by Hedley's bedside for five days. On the fifth day, Hedley suffered a second stroke and died. He was seventy-nine. Cousins loved, admired and respected his father and he was distraught to lose him. He also worried about his mother and how she would cope on her own.

Later in 1982, several months after Hedley's death, Cousins visited UW's pain centre. Loeser, who was 'larger than life' according to Cousins, painted a picture of the journey patients took before reaching UW's pain centre. In his characteristic 'big' warm voice, Loeser described how, in the years leading up to their referral to the clinic, many patients were like a billiard ball caroming off one cushion to the other, because each specialist they consulted was at a loss to explain their symptoms so referred them to another specialist. Many of these patients took multiple opioids from different doctors and, despite using them, they still lived with unrelenting pain. Cousins nodded, knowing that his patients also depended on high doses of opioids that did not relieve their pain. 'That's why we try to help patients realise opioids may not be helping

[2] Loeser, interview, 21 April 2019; John Loeser, 'Wilbert E. Fordyce, Ph.D. 1923–2009', *Pain* 148 (2010): 1–2.

them', Loeser said. 'As you and I both know, opioids can sensitise pain receptors, flaring up the pain.'[3] Loeser told Cousins that one of his pain team's top priorities was to help patients gradually reduce and discontinue their use of opioids. 'Their pain doesn't get any worse and often decreases, much to each patient's surprise', he added.

Cousins's visit to UW impressed on him the urgent need to expand FMC's multidisciplinary pain services. He returned to Adelaide more determined than ever to secure the funding he required despite the bleak funding situation: the hospital's financial report for 1981 described an impasse, with a $2.4 million shortfall following protracted budget negotiations with the South Australian Health Commission.[4]

Confiding this news to Bonica in a phone call, Cousins asked for his mentor's advice. 'You must nurture politicians and government officials because they hold the purse strings', Bonica counselled. Yet, as a doctor rather than a lobbyist, Cousins knew he was a beginner, learning by trial and error because hospital department heads did not receive media and advocacy training as they often do today.[5] During his first five years at FMC, he felt frustrated with his lack of progress in making pain management a political issue or government priority. It distressed him, and, at times, he felt deeply despondent; he resolved to 'ratchet up' his efforts.

Through his 'powerbroker' brother Keith, the celebrated president of the Advertising Federation of Australia, Cousins had observed the power of collective advocacy efforts. He intended to replicate his older brother's tactics on the national political front to raise awareness of pain. It involved persuading the leaders of the Australasian Chapter of IASP to launch a campaign to educate politicians and health bureaucrats about the personal and societal costs of untreated pain. Members agreed, so Issy Pilowsky, the chapter's president, invited the then federal health minister, Michael MacKellar,[iv] to open the chapter's 1982 scientific meeting, its fourth. Two years later, Pilowsky commissioned the health economist Paul Gross to undertake a pilot study on the cost of chronic pain to provide the evidence needed to educate government

[3] J. Loeser, interview by GKD, 15 November 2019.

[4] *Flinders Medical Centre Annual Report 1981,*6.

[5] Simon Marginson and Mark Considine, *The Enterprise University: Power, Governance and Reinvention in Australia* (Cambridge: Cambridge University Press, 2000), 66.

officials. That year, the Australasian Chapter of IASP shortened its name to the Australian Pain Society (APS).[6]

At the end of 1982, FMC's budgetary situation was dire, with bed closures, cancelled elective surgery and high staff vacancy rates. Forecasts for the next year were equally bleak. Surprisingly, against this backdrop, pain unit consultations increased by twenty-five percent in 1982 and the anaesthesia department's research interests expanded to include cancer pain, reflex sympathetic dystrophy, pain secondary to vascular insufficiency and the use of epidural stimulators for a wide variety of chronic pain syndromes.[7] Through stealth, tenacity and sidestepping obstacles, Cousins had prevailed, though, as it transpired, this was just a foretaste of his next move.

During 1983, Cousins seized two opportunities with gusto: a review of the hospital's surgical services and a review of its clinical psychology services. Inundating both review committees with data, he implored the hospital's leaders to reactivate planning for a day surgery unit and boost the pain unit's psychology services. The master strategist, he wrote two encyclopaedic submissions, basing them on painstakingly assembled facts and figures. At meetings of the review committees, his passionate delivery was persuasive, and the committees agreed to support his proposals.[8]

In late 1983, Dominick P. Purpura, Stanford University's dean of medicine, wrote to Cousins, inviting him to apply to be the medical school's head of anaesthesia. Purpura also approached Ron Miller, chairman of the University of California–San Francisco's Department of Anesthesia and Perioperative Care and a pioneer in anaesthesia research. Cousins felt flattered, and the opportunity exhilarated him, but he and Michele were uncertain about moving their children to America. Nevertheless, he set to work, meticulously preparing a proposal outlining his impressive research achievements and publications. After binding it in a vivid red cover, he carried it with him on the flight. At Stanford, Purpura told him the anaesthesia department's budget was US$ 1 million each year, equivalent to A$ 5 million today. Cousins was astonished,

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[6] Godden, *Australian Pain Society*, 39–41.

[7] *FMC Annual Report 1982,* 21.

[8] FMC Planning and Development Committee, minutes, 21 December 1983, Box 15, Folder 7, Fraenkel Collection.

realising such generous funding would enable him to build a comprehensive pain research program.

A few weeks later, he received a faxed letter from Purpura offering him the position. In 'two minds' about leaving Australia, he and Michele 'paced the bedroom floor for several nights, debating the pros and cons' of uprooting their children. Cousins was worried about his mother; he wanted to live close to her in case she needed help. Michele felt the same way about her elderly parents. The couple was also keen for their children to grow up in Australia. Still, Cousins knew it would be challenging, or even impossible, to establish a pain centre of international standing in Adelaide given the South Australian Health Commission's continuing budget cuts. The most recent, $600,000, resulted in stringent cost control measures being implemented across FMC.[9]

As Cousins wrestled with this decision, he received a letter from his trusted mentor. 'Stanford really wants you there', Bonica disclosed. Admitting that many serious problems existed in Stanford's anaesthesia department, Bonica wrote: 'They believe you are the one that can solve them. I wish you the very best in your decision-making process.'[10] Shortly afterwards, a friend from Stanford faxed Cousins a newspaper article announcing that Purpura had returned to his former position as dean of the Albert Einstein College of Medicine in New York. Suspecting that 'all bets would be off' because a new dean might not honour the financial commitments Purpura had made, Cousins and Michele decided against moving to Stanford.

On the national front, debate was brewing about the use of heroin for pain relief in patients with terminal cancer. It would profoundly affect the FMC team, though they were unaware of it at the time. South Australia's progressive Labor government supported the use of heroin for pain relief in patients with terminal cancer despite repeated studies failing to support the drug's effectiveness.[11] At the same time, the federal Labor government was examining the issue, which Cousins called a 'political hot potato'.

In early 1984, the South Australian health minister, John Cornwall,[v] telephoned Cousins to discuss the 'heroin issue'. When Cornwall called, Cousins was recovering from surgery for surfer's ear, a condition in which the ear canal narrows so much it is difficult to hear. The

[9] *FMC Annual Report 1982,* Box 12, Folder 2, Fraenkel Collection, 21.

[10] JJB to MJC, 24 February 1984, Box 30, Folder 9, Bonica Papers.

[11] Godden, *Australian Pain Society*, 54.

surgery left Cousins with severe tinnitus—a ringing in the ears that can also manifest as hissing, whooshing or buzzing. Cornwall asked him to lead a study on whether heroin relieved severe cancer pain. Cousins's initial reaction was to tell the minister to 'jump in the lake' because he felt so unwell. Fortunately, he hesitated before responding, asking himself what Bonica would have done in this situation. Bonica vigorously supported the use of heroin for treating intractable pain,[12] so instead of rebuffing the health minister, Cousins suggested that he and Cornwall meet at FMC. Cornwall agreed. Before ending the call, Cousins added: 'Look, if you really feel we should pursue this, I'll do my best to get people involved, but I can't promise anything.'

On the day of the ministerial meeting, Cousins stood with Cherry on the driveway at the front of the medical centre waiting for the minister to arrive. As well as his own determination to gain the funding he required to build a standalone pain centre, he bore the weight of his colleagues' expectations on his shoulders; he felt it deeply. As he waited for Cornwall's arrival, he rehearsed in his head what he planned to say to the minister.

Cherry remembered several members of the university's public relations team and a few photographers standing in front of him. Once Cornwall arrived, the camera flashlights burst into action, momentarily blinding Cherry. 'It was bells and whistles because Michael wanted to use it as a publicity thing for his own betterment', Cherry stated. 'It was quite a show, and fair enough because the pain unit was really something special. It was certainly a big occasion for Flinders Medical Centre and the pain unit.'[13]

Cousins and Cherry escorted Cornwall and his two male staff through the medical centre's glass sliding doors into the foyer, which O'Grady described as 'not particularly grand'.[14] A wide staircase in front of them led to the first floor but they veered right, passing a little shop that sold newspapers, chocolates and toiletries, then waited for the lift to Cousins's third-floor office.

Once the guests settled at the meeting table, O'Grady offered them a cup of tea, and while she poured it, Cousins and Cherry chatted with Cornwall and his 'minders'. Then O'Grady passed around the wholemeal cookies Michele had baked late the previous evening. Teacups rattled

[12] JJB to Harold Merskey, 3 January 1984, Box 4, Folder 124, Bonica Papers.

[13] Cherry, interview.

[14] O'Grady, interview.

on their saucers while Cousins briefed Cornwall about the two patients he had invited to the meeting. One, a woman in her fifties, struggled with cancer pain, and the other, a man in his forties, suffered from chronic lower back pain following a workplace injury.

After the guests finished afternoon tea, O'Grady escorted the two patients into the cramped office. They shook hands with Cornwall, then sat on what Gourlay described as 'standard issue hospital chairs upholstered in a drab patterned fabric'.[15] For a moment, a hushed silence filled the crowded room; the atmosphere was tense with anticipation. The woman fidgeted, crossing and uncrossing her legs. First, the male patient told the minister about his treatment regimen at the pain clinic, describing his exercise program and counselling. Soon, the woman relaxed and joined in the conversation. She explained how an epidural morphine pump had eased her unrelenting pain. Neither patient had used heroin.

Cornwall asked the pair several questions, then thanked them for sharing their stories with him. After the patients departed, Cousins recalled that Cornwall caught his gaze. 'I'm getting the feeling this heroin business is a bit of a distraction', Cornwall admitted. 'The actual issue is we're not applying what we know about the treatment of pain.'

The following Friday, Cornwall's wife, Patrice, arrived at FMC's outpatient department to consult Cousins about her lower back pain.

'I've had back pain for years after an accident', she said, wincing and rubbing her back. 'I've tried everything. Nothing's helped.'

He asked Patrice a series of questions then examined her. Afterwards, he told her that the acute pain caused by her original back injury had transitioned to chronic pain.

'Sadly, it's impossible to cure chronic pain because it's a malfunction in the way your nervous system processes pain signals', he explained. 'Fortunately, I can help you better manage your pain so it doesn't affect your life so much.'

A few weeks later, Patrice returned after embarking on a daily regimen of stretches and gentle strengthening exercises. She had also commenced a cognitive behavioural therapy program with Harris. Cousins asked her how she was feeling.

[15] Gourlay, interview.

Patrice beamed. ‘I’m much better, thank you. I’m thrilled.’

Shortly afterwards, Cornwall invited Cousins to the first of a series of meetings to discuss the funding required to build, operate and staff a standalone pain centre. The pair ‘got along well’, according to Cousins, perhaps because both were reformers. ‘We saw eye-to-eye’, he recalled. ‘We both wanted to improve health care.’ An ardent reformer, Cornwall wrote in his 2017 memoir that his intention as health minister was to redefine health ‘as a state of physical, emotional and social wellbeing, not just as the absence of disease’.[16]

In letters O’Grady typed to Cornwall, she witnessed Cousins’s ‘gentlemanly persuasiveness’ firsthand, noting his political savvy in the way he interacted with Cornwall and the hospital administrators. When asked if he was manipulative, she responded: ‘I would say yes, but in a gentle way.’[17] Cherry was blunt. ‘Michael was extremely entrepreneurial’, he remarked. ‘Promising the Flinders’s pain centre would be a world-class facility, he put Cornwall into an impossible position where he had to say yes. Cornwall had no other option.’[18]

On 23 July 1984, Cousins, FMC’s director of nursing and an associate professor in surgery wrote a memorandum to the hospital’s administrator, J. M. Blandford: ‘You are now aware of the fact that the Pain Management Unit has been operating under makeshift and highly unsatisfactory conditions for the last eight years.’ In deeply empathetic and passionate terms, they reiterated Cousins’s inexorable pleas about the unsuitability of treating pain unit patients in the recovery area of the operating theatres, the ‘temporary’ day surgery unit and scientific laboratories. The memorandum implored:

> On the basis of an existing patient load, the inability of current inpatient and outpatient facilities to cope with the workload and on humanitarian grounds of providing a more appropriate service for patients who have endured great suffering, we strongly recommend an appropriate area be developed specifically for the treatment of patients with chronic, intractable pain.

[16] John Cornwall, *After Work, after Play, after All: A Political Memoir* (Adelaide: Bookpod, 2017), 149.

[17] O’Grady, interview.

[18] Cherry, interview.

The administrator's office acknowledged the memorandum with a date stamp: 31 July 1984. In the top left-hand corner, underlined in thick red ink, was typed in small print: 'Planning and Development Committee 1/8/84. Additional Agenda Item.'[19]

Dialling up the pressure, four days after sending the original memorandum to Blandford, Cousins sent another one, this time co-signed by Cherry.[20] It reminded Blandford of the urgent need for a dedicated area for the Pain Management Unit. 'You will be aware of the strong support from the South Australian Minister for Health and the Health Commission in providing funds for the facility', they wrote, adding that the president of FMC's volunteer committee had agreed to provide financial support to build the Pain Management Unit 'in the form of a 30–50 percent subsidy of funds provided by the South Australian government'. In the memorandum to Blandford, Cousins revealed that he had informed Cornwall of the volunteer committee president's commitment:

> He [the volunteer committee president] has asked me to confirm the allocation of an area and its costing for capital and recurrent funds. I am requested to meet with him as soon as possible to determine the South Australian Health Commission's financial contribution. Thus, I am writing with a description of the physical facility required. In our discussions with Mr C. Ford, Hospital Engineer, it seems that the 'shed' area above the current operating theatre suits our requirements best.[21]

The exhaustive five-page enclosure included a sketch of the proposed pain centre (see Figure 14) and detailed the physical areas required: a reception area; a male and female change room; a scrub room; a narcotic treatment/stabilisation area fitted with two beds and with 'some outlook to the exterior'; a major pain relief procedure room fitted with an image intensifier and facilities for background music. 'Another important consideration is that the room should be much less threatening than the standard operating room and should ideally have windows admitting external light and should have attention to the provision of a more humane environment.' Added to the list were a diagnostic and therapeutic nerve block area; a glassed-in sister's office; a four- to six-bed holding area for patients to rest after a procedure; a large

[19] MJC, Villis Marshall and Aileen Monck, memorandum to J. M Blandford, 23 July 1984, Box 12, Folder 4, Fraenkel Collection.

[20] MJC and David Cherry, memorandum to J. M. Blandford, 27 July 1984, Box 12, Folder 4, Fraenkel Collection.

[21] MJC and David Cherry, memorandum to J. M. Blandford, 27 July 1984.

director's office and offices for several staff members; and a twenty-four-seat waiting area that was 'a little more "homely" than the average hospital waiting area, with an "outlook".'[22]

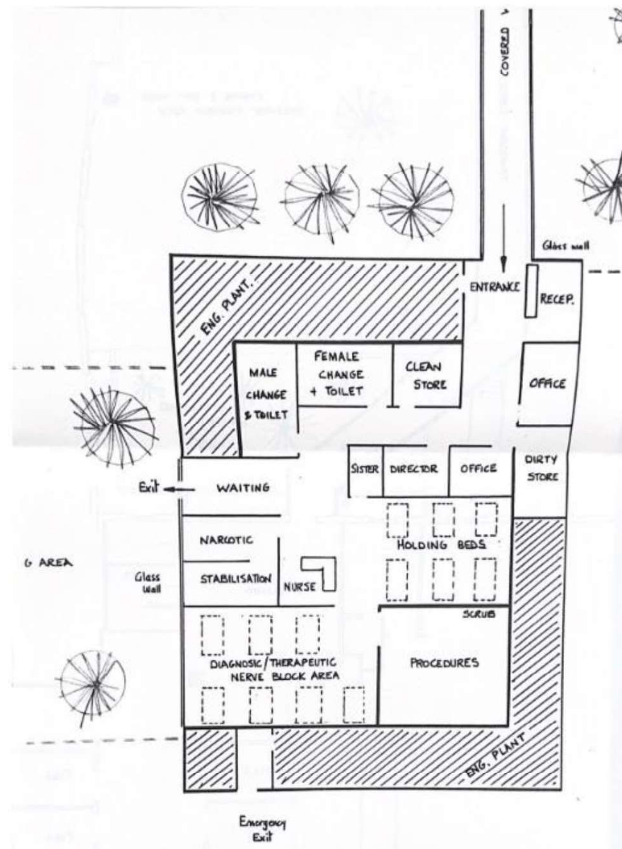

Figure 14: Sketch of the proposed pain unit, Flinders Medical Centre, 1984.

Source: Fraenkel Collection, Flinders University.[23]

Checkmate!

Soon thereafter, the South Australian Health Commission provided a $355,000 capital grant plus equipment to FMC, supplemented by $100,000 from the hospital's volunteer service, equivalent to a total of $1.3 million today. Within weeks, FMC's planning and development committee commissioned an architect to design a state-of-the-art interdisciplinary pain

[22] MJC and David Cherry, 'Pain Investigation and Management Unit. Description and Justification of Physical Areas Required', 27 July 1984, Box 12 Folder 4, Fraenkel Collection.

[23] MJC, 'Sketch AD 5: FMC. Level 2, Building B. Proposed Pain Unit', 1984, Fraenkel Collection.

management facility and construction soon commenced.[24] John Cornwall, with Ronald Melzack in attendance, launched the unit on 26 August 1985 (see Figure 15).[25]

Figure 15: Launch of the Flinders Pain Unit: (L to R) David Cherry, Ronald Melzack and John Cornwall, 26 August 1985.

Courtesy Flinders Medical Centre.

'We were incredibly fortunate to have this unit', Cherry reminisced:

> We had a room for our clinical research rather than using the hospital's recovery ward, four rooms for team members to interview patients, and a nice waiting area. We had a room for all of our research documents to be housed rather than cramming them into our overcrowded offices. It was a wonderful unit.[26]

Gourlay agreed: 'It took Michael's doggedness and immense driving force to secure a freestanding pain unit.'[27] Cousins also secured ongoing funding to recruit research and clinical staff.[vi] Finally, his relentless eight-year crusade had paid dividends. Perhaps when Fraenkel appointed him, he sensed the young anaesthetist's ambition, audacity and powers of persuasion would enable him to realise his vision against all odds?

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[24] GF, 'FMC Planning and Development Committee Agenda for Meeting on 8 August', Box 12, Folder 4, Fraenkel Collection; GF, 'Agenda: FMC Planning and Development Committee', 16 October 1984, Box 12, Folder 4, Fraenkel Collection.

[25] *FMC Annual Report 1985*, 6.

[26] Cherry, interview.

[27] Gourlay, interview.

Chapter Eight: Global Ascendency

The year 1984 was a momentous one for Cousins. In August, he flew to Seattle for IASP's Fourth World Congress on Pain. Michele joined him on the trip because he was to be appointed IASP's president-elect at the congress. Also, the couple wanted to celebrate Michele's fortieth birthday in a memorable way.

Louisa Jones recalled how Cousins was adept at 'working the room'. She sensed he had 'his eyes on the IASP presidency at an early stage', and it did not take him long to assess the leadership aspirations of his fellow council colleagues. 'Michael had a personal ambition to be an important person and rise to heights', Jones recollected, 'but not in a "Boy, I could be this big wheel", sense. I never thought of him that way. I thought of him as a very hardworking guy, and definitely dedicated to the pain field.' Jones valued Cousins's irrepressible enthusiasm, energy and commitment to advancing pain medicine. 'Like John Bonica, he realised that unless someone was prepared to roll up their sleeves and put in the hard yards, the treatment of pain would never improve.'[1]

Gourlay admired Cousins for 'getting in on the ground floor' with Bonica to advance pain medicine. 'Michael was charismatic, empathetic and dedicated to his patients', Gourlay stated, adding:

> There's no question his mission was improving the lot of patients. But his driving force was a complex mix of passion for pain medicine and his patients and personal ambition. If he could make a name for himself along the way, very well and good. Anyone who didn't admire him would be trite in the extreme.[2]

Cousins felt honoured to take on the role of president-elect, especially because it meant he would work alongside Melzack, the association's president. In awe of Melzack, he was relieved when they quickly developed a strong rapport and found they agreed on the association's future focus. Melzack was eager to revamp and enlarge IASP's committee structure, a goal they

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[1] Jones, interview.

[2] Gourlay, interview.

accomplished together. 'I set the stage for Mike Cousins to come in and really start making it grow', Melzack remarked.[3]

Contemporaneously, Cousins promoted the idea of increasing IASP's focus on acute and cancer pain because the association had focused on chronic pain since its inception. Several scientists from among the membership opposed this proposal, but Melzack supported it. To 'move things along', Melzack and Cousins set up a taskforce on acute pain management chaired by the acclaimed anaesthesiologist Brian Ready, who was known as the 'Father' of acute pain management.[4] The taskforce created a manual on the treatment of acute pain that, once completed, would help the association become recognised as an authority on acute pain. It also helped IASP attract pain researchers and clinicians to congresses where they could learn about the explosion of knowledge in pain diagnosis, prevention and treatment.

The membership fees IASP and APS generated were insufficient to fund the organisations' ambitious educational and research activities. Nor were donations or occasional government grants large enough to cover these costs. According to Jones, IASP had a 'nickel and dime' budget. We didn't have any money.'[5] The APS was in a similar position. This meant that both organisations depended on financial support from pharmaceutical companies and other private sector organisations to hold pain congresses, conduct lecture tours and offer educational programs. Given the lack of government grants to support pioneering research in new fields of medicine, this was a common practice; however, for the pain community, it would have tragic consequences.

In April 1985, at the suggestion of a Purdue medical marketing representative, Bonica introduced himself to Richard Sackler, vice-president of Purdue Frederick Company. Six months earlier, Purdue had launched MS Contin, a controlled-release oral morphine sulphate medication, in America.[6] A Sackler-owned company had marketed the analgesic in England

[3] R. Melzack, interview by J. Liebeskind, 16 October 1993, Ms. Coll. no. 127.3. John C. Liebeskind History of Pain Collection, History & Special Collections Division, Louise M. Darling Biomedical Library, University of California, Los Angeles.

[4] Alon Winnie, '1999 Gaston Labat Awardee: Dr. L. Brian Ready', *Regional Anesthesia and Pain Medicine* 24, no. 6 (1999): 497.

[5] Jones, interview.

[6] Patrick Radden Keefe, *Empire of Pain: The Secret History of the Sackler Dynasty* (New York: Doubleday, 2021), 160 and 477.

for the relief of severe cancer pain since 1980, and it was widely used in palliative care.[7] It enabled cancer patients to remain at home rather than having to visit the hospital for intravenous infusions of morphine. After reading Purdue's information about MS Contin, Bonica wrote to Sackler:

> I am totally persuaded that this preparation will play a very important and indeed critical role in improving the management of patients with cancer pain, because it will provide patients with 12-hour pain relief and produce more evenly sustained analgesia. I believe that the drug will also be useful in managing patients with severe acute pain consequent to surgical or accidental trauma.[8]

Ten years later, Purdue launched oxycodone in America. It was a new slow-release form of morphine that Purdue named OxyContin. The company intended to market it to doctors for chronic non-malignant pain despite a lack of evidence supporting the use of opioids in managing chronic pain. OxyContin was twice as potent as morphine and much stronger than MS Contin. In the 1990s, doctors were still cautious about prescribing morphine because of its addictive potential, presenting Purdue with a dilemma: how to convince the medical profession that OxyContin could be safely used by people living with chronic pain without the risk of addiction or abuse.

What followed was an aggressive, fraudulent and unethical marketing campaign that would ultimately contribute to a devastating opioid epidemic.[9] It is just one example of how science and advertising refashioned medicine, as noted in the citation for an online exhibition at the Geoffrey Kaye Museum of the Australian and New Zealand College of Anaesthetists for its exhibit *The Development and Labelling of Pharmaceuticals for the Treatment of Pain.*[10]

In April 1985, Bonica asked Sackler for a grant of $15,000 to contribute towards the cost of paying a medical illustrator to create 450 diagrams in his second edition of *Management of Pain in Clinical Practice.* He wrote that another pharmaceutical company that specialised in local anaesthetics had provided $20,000 towards the total cost of $45,000 for illustrations. 'From the viewpoint of your company', he stated, 'I can assure you that the use of your

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[7] Keefe, *Empire of Pain*, 160.

[8] JJB to Richard Sackler, 30 April 1985, Box 5, Folder 111, Bonica Papers.

[9] Keefe, *Empire of Pain*, 183.

[10] Geoffrey Kaye Museum of the Australian and New Zealand College of Anaesthetists, *From Snake Oil to Science: The Development and Labelling of Pharmaceuticals for the Treatment of Pain*, online exhibition, accessed 13 August 2024, https://www.geoffreykayemuseum.org.au/snakeoil/.

preparation and its advantages will be appropriately emphasized' in the textbook,[11] a promise he repeated in later letters.[12] That grant would be the first of many Sackler provided. Five years later, when Bonica's text was published, he thanked Sackler for Purdue's support for his book and IASP initiatives:

> Once again, I wish to thank you for providing financial support for the annual John J. Bonica lecture. Please express my appreciation to other officers and members of your company for this support. With warm personal regards and best wishes. P.S. I do hope you have received the two volumes representing the second edition of *Management of Pain*, which I have autographed for you and instructed my publisher to send to you. My appreciation of support of this effort is indicated in the acknowledgment section.[13]

In the mid-1980s, Cousins and Philip Bridenbaugh had embarked on creating the second edition of *Neural Blockade* to reflect rapid advances in the understanding of regional anaesthesia, pain and its treatment. They invited forty-one contributors from ten countries, twenty-four of them new, to expand and rewrite existing chapters. The updated text included eleven new chapters on chronic pain.

Meanwhile, Australia's National Health and Medical Research Council (NHMRC) had established a working group charged with developing clinical guidelines for severe pain. The NHMRC invited Cousins to participate in the working group, which included several distinguished Australian pain medicine professionals. The council's chair, the distinguished paediatrician Henry Kilham, asked the working group to base the guidelines on the latest research to improve community and government awareness of severe pain and the urgent need for advancements in pain research, treatment and education.

By the mid-1980s, FMC's pain unit had attracted substantial media coverage. In August 1985, the *Weekend Australian* published a feature story about the group's development of a morphine pump for relieving cancer pain.[14] The journalist, Louise Boylen, described the technique in minute detail, aiming to demystify it. The morphine pump enabled cancer patients to remain

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[11] JJB to R. Sackler, 30 April 1985, Box 5, Folder 111, Bonica Papers.

[12] JJB to R. Sackler, 19 February 1987, Box 5, Folder 111, Bonica Papers.

[13] JJB to R. Sackler, 21 May 1990, Box 5, Folder 111, Bonica Papers.

[14] David Cherry et al., 'A Technique for the Insertion of an Implantable Portal System for the Long-Term Administration of Opioids in the Treatment of Cancer Pain', *Anaesthesia and Intensive Care* 13 (1985): 145–52.

mobile and out of hospital, Boylen wrote, because community nurses could top up the catheter in the comfort of a patient's home.[15]

An intensely private person, Cousins nevertheless embraced his role as the public face of pain medicine at FMC with his usual vigour, following Bonica's example of seeking publicity for pain medicine to draw attention to it and attract funding.[i]

Displaying a natural ease with journalists, he spoke eloquently, according to his colleagues. Early in his career, he demonstrated an instinctive ability to translate complex scientific concepts into catchy headlines and sound bites. During media interviews, he spoke with conviction and passion about the plight of people living with pain. It antagonised some colleagues, who accused him of blatant self-promotion and grandstanding. They claimed he was eager to be seen as THE authority on pain in Australia and the field's figurehead. Though his motives might have included an element of personal brand building and ego, it was an essential aspect of raising awareness of the need for investment in research and pain management services.

In early 1996, Cousins wrote to Ross Holland, dean of the Faculty of Anaesthetists within the Royal Australasian College of Surgeons, insisting that the anaesthesia profession had been slow to embrace pain research, teaching and treatment. Urging Holland to advocate for the establishment of pain management units in all hospital anaesthesia and intensive care departments, this missive signalled the launch of Cousins's campaign to raise the priority medical professionals gave to managing a patient's pain, something he believed many doctors neglected.[16]

Two years after APS commissioned Paul Gross to estimate the economy-wide costs of chronic pain, the economist presented the preliminary report at the society's 1986 scientific meeting.[17] In *The Economic Costs of Chronic Pain in Australia*, Gross estimated the annual cost of chronic pain was $7 billion, concluding that this was sufficient to justify federal government intervention into pain management.[18] The society shared the report with politicians and

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[15] Louise Boylen, 'Clinic Breaks the Pain Barrier', *Weekend Australian*, 17–18 August 1985, MJC Private Collection.

[16] MJC to Ross Holland, 6 February 1986, MJC Private Collection.

[17] Godden, *Australian Pain Society*, 55.

[18] Paul Gross, 'The Economic Costs of Chronic Pain in Australia', Eighth Annual Scientific Meeting of the APS, Melbourne, 5–7 February 1986, MJC Private Collection.

bureaucrats. 'Disappointingly, no-one in political circles was listening', Cousins lamented. 'Some people within government ranks were openly hostile towards our attempts to put pain on the national healthcare agenda.'

Two months later, amid continuing financial constraints and budget overruns, FMC celebrated its tenth anniversary.[19] Michele organised a sumptuous buffet luncheon at Highfield to celebrate the anaesthesia department's anniversary, posting formal gilt-edged invitations from 'Professor and Mrs Michael Cousins'.[20] That year's annual report included an article about the new Pain Management Unit, accompanied by a photograph of the stylish building, which, complying with Cousins's specifications in his letter to Blandford,[21] boasted enormous windows along two external walls (see Figure 16). By then, the unit's staff conducted 1,700 outpatient pain procedures annually.

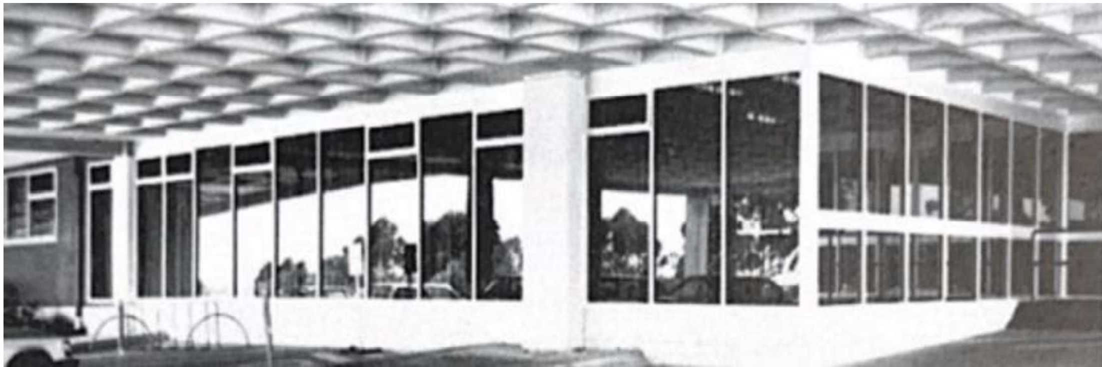

Figure 16: Pain Management Unit, Flinders Medical Centre, August 1985.

Source: *FMC Annual Report*.[22]

During this period, APS's leaders tried to make the society more inclusive. Some members thought it was a bit of an 'old boys' club', though one renowned female member disagreed with this assertion. From the mid-1980s onwards, nurses, psychologists, physiotherapists and dentists joined, and, in 1987, Jack Gerschman was the first dentist elected to the society's council.[23] That year, members elected Robyn Quinn as a state councillor, paving the way for

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[19] *FMC Annual Report 1986*, 3.

[20] Michele Cousins, 'Invitation to Professor and Mrs Fraenkel', June 1986, Box 12 Folder 2, Fraenkel Collection.

[21] MJC and David Cherry, 'Pain Investigation and Management Unit. Description and Justification of Physical Areas Required'.

[22] *FMC Annual Report 1986*, 5.

[23] Godden, *Australian Pain Society*, 35.

health professionals other than doctors, and particularly anaesthetists, to influence the organisation.[24] As the first woman and first nurse appointed, Quinn's election marked a crucial milestone in the society's history.

In 1987, Melzack and Cousins took a crucial step towards building a highly skilled pain medicine workforce by developing a curriculum for educating pain specialists. Given the advances in pain medicine research and treatment, they believed it was the right time to launch a curriculum, and so persisted in the face of protests from some IASP Council members who insisted that it would be impossible to secure agreement on what topics to include and which ones to exclude. Howard Fields, a pre-eminent neurologist from the University of California, San Francisco, led a taskforce to create the training program, impressing Cousins with the skilled way he responded to opposing views and the often-heated exchanges between taskforce members.[25]

The pain medicine movement under John Bonica's leadership was gaining momentum when, in January 1987, Cousins embarked on a twelve-month sabbatical at Stanford University as a visiting professor of anaesthesia.[26] The family rented a house on the Stanford campus, and Cousins resumed his habit of riding a bicycle to his office and the hospital. Six-year-old Jane and Chris thought it was hilarious the way their father fastened rubber bands around the bottom of his trouser legs to stop them catching in the greasy chain. It was effective, so Cousins did not care if it looked a bit odd. The family's Stanford friends warmly welcomed them.

While in America, Cousins was invited to present five eponymous orations.[ii] One of them was the inaugural John J. Bonica Distinguished Lecture, which accompanied his appointment as the University of Washington's John J. Bonica Visiting Professor.[27] At UW, on 15 May 1987, he presented 'Spinal Opiates. Major Advance in Pain Relief or Gimmick?'[28] At the banquet following the lecture, Cousins announced Bonica's appointment as IASP's honorary founding president, and he praised Bonica and Emma effusively, much to Bonica's delight. 'From my own personal observation and the numerous comments, I have heard since your visit, your

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[24] Godden, *Australian Pain Society*, 50.

[25] MJC, interview by M. Meldrum, 32.

[26] MJC to William Hamilton, 8 July 1987, Box 2, Folder 29, Bonica Papers.

[27] JJB to R. Melzack, 10 April 1987, Box 4, Folder 120, Bonica Papers.

[28] 'John J. Bonica Distinguished Lecture (Multidisciplinary Pain Center, University of Washington Medical Center, 1987)', poster, Bonica Papers.

lecture was a truly outstanding success', Bonica penned in a letter to him late that night. 'The lecture was very informative and, of course, of great interest to those of us in the department involved in pain management. I also know that the residents and other colleagues who heard you are most appreciative of your excellent presentations.'[29]

Figure 17: John Bonica and Michael Cousins, Seattle, 1987.

Courtesy Michael and Michele Cousins.

Cousins also spent a week as the 1987–88 Stuart C. Cullen Visiting Professor in the anaesthesia department at the University of California, San Francisco.[30] In a letter to Cousins, the department's chair, Ronald Miller, suggested that he and Cousins establish an exchange program: 'recognizing that your department is strong in areas which we are either beginning or do not have expertise in at all'.[31]

During his year at Stanford, Cousins's mother, Marjorie, visited and accompanied the family to Hamburg, Germany, for IASP's Fifth World Congress on Pain. It was late July 1987 and IASP was appointing Cousins as its fifth president during the event. The family flew from San Francisco to Zurich, then drove to Rome in the middle of a blistering heatwave. The rental car did not have air-conditioning, so they sweltered. Despite the heat, they were in high spirits because, along with a delegation of IASP's leaders,[iii] they were heading to Rome for an audience with Pope John Paul II at his summer residence, Castel Gandolfo Palace, to brief him about IASP (see Figure 18).[32] The day after the audience, one of the Pope's staff gave Melzack

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[29] JJB to MJC, 15 May 1987, Box 2, Folder 29, Bonica Papers.

[30] Ronald Miller to MJC, 7 July 1987, Box 2, Folder 29, Bonica Papers.

[31] MJC to Ronald Miller, 24 September 1987, Box 2, Folder 29, Bonica Papers; Ronald Miller to MJC, 6 October 1987, Box 2, Folder 29, Bonica Papers.

[32] JJB to Corrado Manni, 15 May 1987, Box 4, Folder 83, Bonica Papers.

a statement signed by the pontiff that addressed IASP's work. That day, 'IASP as an organisation had come into its own', Jones later wrote.[33]

Figure 18: Michael Cousins, Lucy Melzack, Ronald Melzack and John Bonica with Pope John Paul II, 1987.

Courtesy Michael and Michele Cousins.

In Hamburg, while Michele, Marjorie and the children enjoyed sightseeing, Cousins commenced his three-year term as IASP's fifth president, participating in the five-day congress and delivering a paper on the spinal route of analgesia for acute and chronic pain.[34] Chuffed to be the second anaesthesiologist to serve in the role—Bonica was the first—he felt euphoric.

During the IASP president's address on Monday 3 August, and in the next edition of IASP's newsletter, outgoing president Melzack warmly welcomed Cousins to his new role: 'Michael Cousins, our new president, brings many strong personal and professional qualities that will make IASP even healthier and more effective. I extend my warmest wishes to him and look forward to working with him.'[35]

This message from a colleague Cousins had revered for two decades reassured him as he embarked on the challenge of leading the association—which 'had a life all of its own' according to Melzack—through a period of change and rapid growth. IASP was transitioning from a focus on chronic pain to one embracing acute, chronic and cancer pain and, at times, 'it was a bumpy ride' because of conflicting views among members.[36]

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[33] Jones, *First Steps*, 24.

[34] Michael Cousins, 'The Spinal Route of Analgesia for Acute and Chronic Pain', *Pain* 30 (1987): S223.

[35] R. Melzack, 'IASP President's Message', *IASP Newsletter* (August 1987), IASP Private Collection.

[36] R. Melzack, interview by J. Liebeskind, 42.

On 6 August at the IASP Council meeting, the first agenda item was Cousins's statement of goals and plans for the organisation during his three-year presidency.[37] Outlining an ambitious agenda, he reiterated his determination to increase IASP's focus on acute pain and his high expectations of council members to serve on committees. To ensure committee members 'pulled their weight', he urged committee chairs to provide him with a report on the contribution of each member 'so a rational decision to terminate or continue the individual's participation could be made'.[iv]

Cousins's president's address, which was published in the August 1987 edition of IASP's newsletter, emphasised his intentions in relation to acute pain: '<u>I would like to state quite firmly that IASP regards acute pain as being at least an equal priority to chronic pain</u>.'[38] He wanted the bold underlining to make clear his intention to 'shake things up'. In an oral history interview a decade later, he said: 'If people didn't like it, it was tough.'[39]

Even Bonica, the master controller, noticed Cousins's indomitable will. In a 1993 oral history interview with John Liebeskind, Bonica remarked: 'I like Mike very much, but he wanted to be the boss. He wanted to have everything under his wing.' Liebeskind shared this view, noting the intense 'currents and crosscurrents' swirling through the membership and Cousins's politicking behind-the-scenes to achieve his goals.[40]

A few years after Bonica retired, Melzack was eager for him to return to the IASP Council. 'Mike didn't say no', Melzack recalled, adding:

> but what he said was the young guys like him would feel like they were taking a major step backwards. He saw himself as the young Turk who was going to overthrow all those stupid old ideas or whatever the hell he was trying to fight. I don't know what battles he was fighting then.[41]

By the end of Cousins's term as president-elect, Melzack observed how he had 'mellowed and grown up'. One example of his maturation was creating the honorary, founding president role

[37] J. Loeser, 'Minutes: IASP Council Meeting, Hamburg', 6 August 1987, Box 55, Folder 59, Bonica Papers.

[38] MJC, 'Incoming IASP President's Message', *IASP Newsletter* (August 1987), IASP Private Collection (original emphasis).

[39] MJC, interview by M. Meldrum, 32.

[40] JJB, interview by Liebeskind, 133.

[41] R. Melzack, interview by Liebeskind, 61.

for Bonica and ensuring the secretariat always invited Bonica to events, a development he had rejected a year earlier when Melzack suggested it.[42]

The 1980s were a thrilling time to be working in pain medicine and Cousins revelled in the opportunity to pursue his goals and play a leadership role with like-minded people. ‘John Bonica had created a global community of pain researchers who had previously worked on their own’, he recollected. ‘Everyone shared a common purpose—we were all trying to solve the puzzle of pain. We were under John’s spell. When he snapped his fingers, we jumped.’

During his year in California, Cousins combined his research and managing Stanford’s pain centre with pursuing his ambitious goals for IASP. While serving as president further reduced his leisure time, he was happy when his children played around him in the study on weekends. He became adept at multitasking, chatting with his twins and Jonathan about what they were doing while he worked. As soon as he took a break, he would run outside with them and play in the garden. Nonetheless, he regretted the way his work took him away from his children. ‘I don’t think I was nearly a good enough father’, he later admitted. Nonetheless, he acknowledged he was fortunate that Michele shared his vision and resolutely made his ambition hers. His central anchor, Michele believed it was more important for her husband to focus on reducing the suffering of people with pain than ‘picking up a tea towel’.[43]

In oral histories recorded during the 1990s, Bonica, Loeser, Liebeskind and Melzack all expressed similar remorse about spending insufficient time with their partners and children. They also admitted that when they were at home or on outings and holidays, they were always preoccupied with IASP matters rather than being ‘truly present’. In the early days of the association, IASP councillors shared a passion for advancing pain medicine that drew them together into a close-knit family. ‘It was a mutual growing together’, Loeser recalled. ‘We learned on-the-job, and through trial and error built a new organisation dedicated to advancing the treatment of pain.’[44] Each councillor poured themselves into their responsibilities almost obsessively; for them it was a vocation.[45] Their lives and professional activities became so

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[42] R. Melzack, interview by Liebeskind, 61.

[43] Michele Cousins, interview by GKD, 23 August 2019.

[44] J. Loeser, interview by J. Liebeskind, 12 July 1993, John C. Liebeskind History of Pain Collection, UCLA, 127.24, 43; JJB, interview by Liebeskind, 40; R. Melzack, interview by J. Liebeskind, 52.

[45] JJB to R. Melzack, 10 April 1987, Box 4, Folder 120, Bonica Papers; JJB to Kathleen Foley, 16 December 1988, Box 2, Folder 137, Bonica Papers.

interwoven, one wonders if these intense relationships became a substitute for their actual families?

The sense among IASP members that councillors formed a cabal concerned Loeser and Cousins. 'It was a double-edged sword because it deterred talented young members from joining committees', Loeser admitted. 'We need to get new people and stop self-regenerating the same people; it's a difficult task.'[46] Cousins concurred:

> It was a club. There's no doubt about it. It was a rather exclusive club, and to some extent that was helpful, because it meant there was very close and ready interchange among the people who were playing a part in developing this new field. But, on the other hand, I think it was something that had to change because there was a very great need to include rather than to exclude. That was a feeling that perhaps didn't develop until a bit later. But nevertheless, I felt it to be a great privilege to be involved.[47]

The buzz of living close to San Francisco in the 1980s energised Cousins, though the suffering caused by the HIV/AIDS epidemic saddened him deeply.[v] Nonetheless, he appreciated living in the same time zone as most of his council colleagues because communicating with them was much simpler than trying to do it from Australia. At the end of the year when he returned to Australia, he knew the difficulty of communicating with councillors in the northern hemisphere would be frustrating. After discussing this issue with Loeser, IASP's secretary, he suggested Loeser spend some time in Adelaide so that the pair could collaborate face-to-face. They wondered how to fund such an endeavour, eventually deciding to apply for a Fulbright Scholarship to enable Loeser to spend a year on sabbatical in Adelaide.[48]

Throughout the 1980s, Cousins's workload skyrocketed to a level he later realised was excessive. In retrospect, he regretted it deeply. Bonica worked at a fiendish pace, and he expected the same from his fellow councillors. Impatient, and with almost impossibly high standards, he harangued his inner circle, pressuring them to match his work ethic. He also berated them if he felt they transgressed, almost like a parent. Nevertheless, playing a leadership role exhilarated Cousins, giving him the energy and resolve to persevere despite the sacrifices it forced on him and his family.

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[46] J. Loeser, interview by J. Liebeskind, 16.

[47] MJC, interview by M. Meldrum, 26.

[48] Loeser, interview, 28 September 2019. See also, MJC and J. Loeser, 'Studies of Epidemiology of Chronic Pain', Fulbright Commission, 1989, MJC Private Collection.

Photographs of Cousins at the time taken with Bonica, Melzack and Wall show a slim man of average height in his early forties with glossy dark hair and chiselled cheekbones. He wears immaculate dark suits, pristine white shirts and thick-rimmed, squarish glasses with rounded corners. His beaming face and relaxed posture suggest he is proud to be included in such an elite group. Clearly, he enjoyed the status his achievements gave him within the pain world and beyond.

By the mid-1980s, Cousins, in collaboration with his colleagues, had published 139 scientific papers, equating to one every five weeks.[49] Routinely juggling multiple research projects and participating in the federal government's working group on severe pain, he wrote and edited chapters for textbooks in his 'spare time'. On 1 February 1986, in collaboration with Garry Phillips, he published a 324-page multiauthor edited volume *Acute Pain Management.*[50] Judging by the reviews, the pain community valued the book.[51] Two years later, the second edition of *Neural Blockade* was published (see Figure 19).[52] As well as editing the text with Bridenbaugh, Cousins wrote two chapters on his own and collaborated on five chapters with colleagues such as Bromage, Cherry and Gourlay.[53] Most of the contributors have died; however, seven who are still alive were interviewed as part of the research for this biography.

Figure 19: Michael Cousins, 1988, the same year the second edition of *Neural Blockade* was published.

Courtesy Michael and Michele Cousins.

[49] Russo, 'The Michael J. Cousins Lifetime Achievement Award'.

[50] MJC and Garry Phillips, *Acute Pain Management* (New York: Churchill Livingstone, 1986).

[51] Karen Waters, review of *Acute Pain Management* by Michael Cousins and Garry Phillips, eds, *Intensive Care Nursing* 3, no. 2 (1 January 1987): 87; Alan Aitkenhead, review of *Acute Pain Management*, by M. J. Cousins and G. D. Phillips, *British Journal of Anaesthesia* 59 (1987): 811.

[52] Michael Cousins and Phillip Bridenbaugh, *Neural Blockade in Clinical Anesthesia and Management of Pain*, 2nd ed. (Philadelphia: J. B. Lippincott Company, 1987).

[53] Cousins and Bridenbaugh, *Neural Blockade in Clinical Anesthesia*, xvi–xix.

Patrick Wall, one of the textbook's reviewers, praised it. 'This excellently produced and edited book is a major advance on the first edition published in 1980', Wall wrote in the journal *Pain,* adding:

> In such an outstanding book characterised by careful scholarly writing, excellent tables and quite remarkable illustrations, it is difficult for a critic to be critical. Happily, there will eventually have to be a third and subsequent editions, but in the meantime, the authors and editors can be very proud of their splendid book.[54]

Around this time, the NHMRC's working group on severe pain completed its guideline and the research council published *Management of Severe Pain*.[55] The guideline called for 'changes in training, knowledge, attitudes and practices of medical, nursing and allied professionals, along with greater public awareness of expectations in the treatment of pain'. Its introduction lamented the inadequate way the Australian health system managed severe pain: 'Pain management in Australia can be described as "islands of enlightenment in a sea of misery".'[56]

Management of Severe Pain also recommended the establishment of university teaching, hospital-based multidisciplinary pain management and research centres around the country. Unfortunately, Cousins claimed, 'it fell on deaf ears' because 'no-one in government circles was listening'. It would be another thirty years before federal and state governments 'started to listen' and even longer before they implemented meaningful action. Despite significant progress, these efforts are still inadequate to meet the soaring demand for pain management services across the nation.

A frequent theme of Bonica's letters to Cousins was the punishing workload of crafting the second edition of *The Management of Pain*, which, he claimed, consumed eighty hours each week.[57] Bonica's remarks provide an indication of the pressure Cousins, too, experienced as he juggled so many commitments while updating *Neural Blockade*, yet he never mentioned this issue in his letters to Bonica. 'You began the second edition of your volume long after I initiated the second edition of *The Management of Pain*', Bonica wrote in 1986 'and you are

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[54] Patrick Wall, review of *Neural Blockade in Clinical Anesthesia and Management of Pain*, 2nd ed., by Michael Cousins and Phillip Bridenbaugh, eds., *Pain* 37 (1989): 252.

[55] NHMRC, *Management of Severe Pain: Report of the Working Party on Management of Severe Pain* (Canberra: Australian Government Publishing Service, 1988), MJC Private Collection.

[56] NHMRC, *Management of Severe Pain*, vi.

[57] JJB Bonica to MJC, 2 May 1984, Box 2, Folder 29, Bonica Papers.

way, way ahead of me'.[58] 'In addition to writing about 65% of the text and developing virtually all of the illustrations', Bonica wrote three years later, 'I have had to spend considerable time to amplify, add, edit, correct, revise, etc. of other chapters. I know that you have had this kind of experience and appreciate the work that goes into trying to put other people's chapters into high-quality material.'[59]

In early 1988, Cousins felt deeply honoured when the American Society of Regional Anesthesia and Pain Medicine invited him to be its inaugural John J. Bonica Distinguished Lecturer.[vi] Michele, who accompanied him to San Franciso for the lecture,[60] said he exuded confidence and had a commanding presence. In a melodious voice, he explained that while surgeons usually provide pain relief for a couple of days after an operation, they rarely put in place a pain management program for their patients once they leave hospital. What was required, he insisted, was 'acute rehabilitation', quickly relieving pain after surgery and trauma, then continuing this care once the patient returned home.[vii]

Towards the end of the oration, Cousins urged his colleagues to conduct research to identify why acute pain sometimes transitioned to chronic pain in order to help prevent chronic pain from occurring. Declaring that acute pain research offered tremendously exciting opportunities for anaesthetists, surgeons, psychologists and scientists to collaborate on ways to reduce the risk of patients developing chronic pain, he encouraged them to embark on these studies as a matter of urgency.[61]

Acute pain services in Australian hospitals, mostly for postoperative pain, became common during the late 1980s, facilitated in part by patient-controlled analgesia devices that delivered a small amount of local anaesthetic combined with a low dose of opioids.[62] With the assistance of FMC volunteers, the hospital purchased extra patient-controlled analgesia devices. FMC's Annual Report for 1989 noted that, within safety limits, patient-controlled analgesia was 'based

[58] JJB to MJC, 26 March 1986, Box 2, Folder 29, Bonica Papers.

[59] JJB to MJC, 28 August 1989, Box 2, Folder 29, Bonica Papers; JJB to MJC.

[60] Michele Cousins interview by GKD, 19 October 2019.

[61] MJC, 'Acute Pain and the Injury Response: Immediate and Prolonged Effects', *Regional Anesthesia & Pain Medicine* 14 (1989): 162–78.

[62] H. Owen et al., 'Variables of Patient-Controlled Analgesia. I: Bolus Size', *Anaesthesia* 44, no. 1 (1989): 7–10; H. Owen, I. E. Mather and K. Rowley, 'The Development and Clinical Use of Patient-Controlled Analgesia', *Anaesthesia and Intensive Care* 16, no. 4 (November 1988): 437–47.

on the premise that only the patient knows how much pain he or she has and how much analgesic is required to relieve it'.[63]

Frustratingly for Cousins, it would take several years for nursing and medical staff across Australia to feel confident about using patient-controlled analgesia devices in hospital wards. While acknowledging that the problem was inadequate training, he still felt exasperated at the time. However, by 2019, he had accepted that it always 'takes time' for new techniques to diffuse into the hospital system. In 1989, the *Medical Journal of Australia* invited him and Mather to co-author an editorial on acute pain. Their article, 'Relief of Postoperative Pain: Advances Awaiting Application', highlighted the glacial pace at which medical professionals adopted the new treatments developed by medical scientists.[64]

Shortly afterwards, and to Cousins's and Loeser's delight, their application to the Fulbright Commission was successful, enabling Loeser to travel to Adelaide for a twelve-month sabbatical from July 1989.[65] Cousins turned fifty that year, and Loeser was pleased to be in Australia to attend his friend's birthday celebrations.[viii]

A project Cousins was impatient to start was the development of guidelines for establishing multidisciplinary pain management centres. However, several IASP members argued that it would be too sensitive and provoke too many arguments; they warned of dire consequences, legal battles and IASP members' opposition. Persisting, a determined Cousins 'twisted John Loeser's arm' to pursue this contentious project. Loeser developed a set of guidelines and, much to his surprise, when he launched it, he heard no 'ripples of discontent'.[66] Since its launch, pain centres across the globe have adopted the guidelines as a standard model for interdisciplinary pain centres.[67]

Loeser enjoyed his time in Adelaide, appreciating the opportunity to work so closely with Cousins, and wrote glowingly of his experiences to Bonica.[68] 'I am delighted to learn that you

[63] *FMC Annual Report 1989,* Box 12, Folder 2, Fraenkel Collection, 8.

[64] MJC and Laurence Mather, 'Relief of Postoperative Pain: Advances Awaiting Application', *Medical Journal of Australia* 150 (1989): 354–56.

[65] MJC, 'IASP President's Message', June 1989, Box 55, Bonica Papers, 3.

[66] J. Loeser, 'Desirable Characteristics for Pain Treatment Facilities: Report of the IASP Taskforce', paper presented at the Sixth World Congress on Pain, Adelaide, April 1990, MJC Private Collection.

[67] IASP, *Multidisciplinary Pain Center Development Manual*, 2021, https://www.iasp-pain.org/wp-content/uploads/2021/11/IASP-PainManagementCenter_toolkit.pdf.

[68] J. Loeser to JJB, 3 September 1989, Box 4, Folder 57, Bonica Papers.

are having such a great time in Adelaide', Bonica replied. 'I am confident that your collaboration with Michael in IASP activities will prove highly productive as will the research.'[69] Two months earlier, Bonica had praised Cousins for his achievements as IASP president:

> During the past 16 years I have often been amazed and flabbergasted by the growth of the association, the quality of the people that make its membership, and most importantly, the leadership that has taken it so far. You should feel justly proud of the accomplishments of your presidency, and I send you warm congratulations.[70]

In an oral history interview in 1993, Loeser told Liebeskind that during his year in Adelaide, he made Cousins dedicate every Wednesday afternoon to working together on IASP priorities. Loeser relished the ideas, research, thinking and conceptual aspects they shared in their conversations.[71] He noted that when Cousins committed to do something, he 'got the job done', adding: 'Mike pulled his weight and didn't sluff it off onto anybody else.'[72]

In 1989, shortly before Christmas, the Cousins made their annual pilgrimage by car from Adelaide to Palm Beach to stay with Michele's mother Poppy; Michele's father, Trenham, had died five years earlier. On the way, and to Jane's and Chris's embarrassment, their father encouraged them to jump out of the car from time to time to do calisthenics on the side of the road. At Palm Beach, the twins remember the fax machine in the second bedroom of Poppy's compact cottage 'spewed out paper at all hours of the day and night'. The device had old thermal rolls, and thirty-metre-long faxes would emerge with IASP's logo on them.[ix] Though Cousins diligently worked during the break, Chris and Jane said he still made them feel as if they were on an endless summer holiday.[73]

Three months later, Cousins hosted IASP's Sixth World Congress on Pain at Adelaide's Festival Centre. In IASP's November 1989 newsletter, he boasted that the Congress Organising Committee had received almost 900 abstracts for presentations in the scientific program, a fifty percent increase in the number of abstracts submitted for the 1987 congress in Hamburg. 'This is a very encouraging indicator of the high level of activity in basic and clinical research in the

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[69] JJB to J. Loeser, 12 October 1989, Box 4, Folder 57, Bonica Papers.

[70] JJB to MJC, 28 August 1989, Box 2, Folder 29, Bonica Papers.

[71] J. Loeser, interview by J. Liebeskind, 43; Loeser, interview by GKD, 21 April 2019.

[72] Loeser, interview by GKD, 21 April 2019.

[73] Jane Cousins, interview by GKD, 7 January 2021; Chris Cousins, interview.

field of pain throughout the world', he wrote. 'The Adelaide Congress promises to be the largest world congress on pain we have so far held.'[74]

Figure 20: (L to R) Ronald Melzack, John Bonica, Michael Cousins, Patrick Wall and Issy Pilowsky, Adelaide, April 1990.

Courtesy Michael and Michele Cousins.

The congress marked the end of Cousins's term as IASP president. Through it, he aimed to attract the world's pain medicine leaders to Australia to inspire local researchers and clinicians. He also wanted to showcase the advances being made in pain medicine by Australians and increase awareness of chronic pain among the general public. The organising committee, headed by Izzy Pilowsky, had worried the lengthy journey would deter delegates flying from the northern hemisphere, yet, to everyone's amazement, 2,000 delegates registered for the event. APS's membership also soared, a trend that would continue throughout the 1990s.[75]

Figure 21: Michael Cousins ending his term as IASP president, Adelaide, April 1990.

[74] MJC, 'President's Message', *IASP Newsletter*, November 1989, Bonica Papers.

[75] Godden, *Australian Pain Society*, 59.

Courtesy Laurence Mather.

Cherry acknowledged that Cousins's charm was a major factor in IASP awarding Adelaide its Sixth World Congress. 'It was a lot about the charisma of Michael Cousins that most of the world leaders in pain attended the congress and visited our Flinders Medical Centre Pain Unit', he remarked. 'We had some very famous pain figures travelling in and out of the pain unit. I spent a lot of time showing them around. I give full credit to Michael.'[76]

Bonica, who was hard to impress, was uncharacteristically effusive in his praise. 'I have expressed the view of most of those who attended that this was the best *World Congress on Pain* ever', he wrote to Loeser, who was elected as IASP's president-elect at the pre-congress council meeting. 'The scientific sessions were of the highest quality.'[77] On the same day, Bonica wrote to Cousins congratulating and praising him for his 'superb and indeed magnificent performance' as IASP president:

> Looking back and considering what has transcended in the IASP during this period, I believe you should feel immensely proud for the vigorous and inspiring leadership you provided the Association. This was the most important factor responsible for the unprecedented degree of progress and the many accomplishments that the Association made in its many programs.

Later in the note Bonica expressed his 'warmest congratulations, affection and thanks' to Cousins and Michele for making the congress 'the best ever!' While recognising that many people organised the event, he added:

> I believe the leadership you provided in planning and running the congress, and the elegance Michele brought to the social events were crucial to the outstanding success of the congress. Certainly, the President's Dinner, that you, Michele and the children hosted in your beautiful home was the magnificent highlight of the congress.[78]

The President's Dinner, a formal event at the end of the congress, took place in a glamorous white marquee in Highfield's garden. Dazzling floodlights beamed on Highfield's sandstone walls making it 'look like the house was singing', according to one guest. 'Distinguished guests were paraded in glamorous horse-drawn carriages into Highfield's circular driveway', Cherry,

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[76] Cherry, interview.

[77] JJB to J. Loeser, 4 May 1990, Box 4, Folder 57, Bonica Papers.

[78] JJB to MJC, 4 May 1990, Box 2, Folder 29, Bonica Papers.

who decided against attending the dinner, remarked. 'Michael loved to put on an occasion.'[79] Cousins was ecstatic that the acclaimed pain medicine pioneers he revered attended. 'They all came, Ron Melzack and his wife Lucy, John Bonica and his wife Emma, Patrick Wall and his third wife Vera, and so many other great pioneers of pain medicine.'[80]

Figure 22: Michael and Michele Cousins, IASP President's Dinner, Highfield, April 1990.

Courtesy Laurence Mather.

Around the same time as the Pain Congress, Roger Vanderfield approached Cousins to 'sound him out' about establishing an interdisciplinary pain centre at Royal North Shore Hospital (RNSH). A new multilevel building had recently opened, and the University of Sydney was keen to establish a professorial chair in anaesthesia and pain management at the hospital, the first of its kind in Australia.[81]

Cousins had ambitious ideas about the budget he would require to establish a pain centre in Sydney. His ordeal at Flinders had taught him to 'nail down an agreement in writing' before accepting any offer. By this time a tough negotiator, he was determined that Vanderfield's proposal specify the pain centre's funding, space, facilities and staffing. He also had high expectations about his personal remuneration and refused to settle for less.[82] By the end of the

[79] Cherry, interview.

[80] MJC, interview by GKD, 24 August 2019.

[81] MJC, 'Application for Funding: Faculty of Anaesthetists Annual Academic Chairs Establishment Grant', 24 July 1990, Centre for Anaesthesia and Pain Management Collection, Royal North Shore Hospital Archive (hereafter Centre for Anaesthesia and Pain Management Collection), Box 25.2, Folder 2.

[82] Stuart Spring, interview by GKD, 24 April 2020. See also, MJC to Stuart Spring, 12 June 1990, Cousins, Medical Biographies Collection.

negotiations, Vanderfield and the Northern Sydney Area Health Service chief, Stuart Spring, had agreed to most of his demands.[83]

Spring said Cousins was one of the most challenging negotiators he had ever encountered. 'Michael Cousins was an expert in driving a bargain', Spring stated. 'He never got angry, always took the high moral ground, and never let you feel you'd agreed at any point in the discussion. And he would often come back with something more after you thought you had nailed a deal.' This 'something more' included page after page of explicit clarifications and requests.[84] 'Michael was determined to get the best deal for pain management.'[85]

[83] MJC to RV and S. Spring, 24 April 1990, Cousins, Medical Biographies Collection.

[84] S. Spring to MJC, 9 May 1990, Cousins, Medical Biographies Collection.

[85] Spring, interview.

Chapter Nine: Starting Over

Cousins left FMC on 17 August 1990,[1] starting his new role as RNSH's foundation chair of anaesthesia and pain management the following week. For the first five months, he commuted from Adelaide to Sydney while his children completed the school year. When the Cousins family returned to Sydney at the end of the year, they stayed with Poppy at her Palm Beach holiday cottage because they could not afford to buy a house in Sydney until Highfield sold; Australia's recession and South Australia's sluggish property market would mean they had a long anxious wait ahead of them.[i] Nevertheless, Michele was thrilled to be back in Sydney, and she quickly reconnected with her family and friends. Cousins was also pleased to spend time with his mother and three siblings.

After a protracted wait, Highfield sold, and Michele found a spacious home in Pymble close to Poppy and Marjorie. The house had an enormous garden for the twins to play in, a tennis court and a pool. Palm Beach was a twenty-minute drive away, and Cousins looked forward to spending his weekends running up and down the beach, body surfing and teaching his twins how to body surf and ride a boogie board.

Mather accompanied Cousins to RNSH as a professor of anaesthesia and analgesia (research) after successfully applying for the role. As they had at Flinders Medical Centre (FMC), the pair worked in parallel, with Mather establishing the centre's research program. Once again, they 'started from scratch'; their only laboratory equipment was the gas chromatograph Mather took with him.[2]

In his negotiations with Vanderfield and Spring, Cousins had secured an agreement for the Northern Area Health Service to partially fund the new Anaesthesia and Pain Management Research Centre as an integrated research, treatment and professional education facility with a focus on acute, cancer and chronic pain.[3] The University of Sydney did not provide any funding, so from the start, the budget shortfall was $1 million.

[1] *FMC Annual Report,1990*, Box 19, Folder 5, Fraenkel Collection, 8.

[2] Mather, interview by GKD, 20 April 2019.

[3] The Anaesthesia and Pain Management Research Centre's mission was to be 'a focus of international standing for treatment, education and research concerning all types of pain in adults and children'. 'Appeal for the Anaesthesia and Pain Management Research Centre', Newsletter no 1, August 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

Cousins recalled that his search for funding dominated 'every waking moment' and kept him awake at night.[ii] While financial constraints were partly because of government cost-cutting and its constant demands for efficiency gains,[iii] it was also because his plans for the centre were so ambitious. The area health service and hospital could not finance the growth targets he envisioned. 'We weren't about to meet Michael's growth targets at the rate he would have wanted', Spring recalled, 'but we didn't treat him any differently to anybody else in the health system. If there was a mismatch, it was Michael's ambition and the legitimate resources available, having in mind the fierce competition for health funding.'[4]

Nonetheless, Spring and Reeve noticed that Cousins was more skilled at lobbying for money than most of his colleagues, making him a source of envy because his new department received more funding than other units at the hospital.[5] 'Michael had very reasonable ambitions, which were all devoted to establishing a world-class pain management service', Spring acknowledged. 'Our inability to meet every one of his expectations disappointed him. He was trying to strike forward at a tough time. It's a credit to him that the pain centre was as successful as it was given the budgetary constraints.'

Determined to raise the capital needed to construct a purpose-designed pain management centre, Cousins set up an appeal board. The first step was forming a steering committee of forty individuals representing a broad cross-section of RNSH staff, major pharmaceutical and medical equipment companies, the Sydney business sector, and key individuals from the community to suggest potential members and kickstart planning of the fundraising project.[iv] Once the appeal board was established, its enthusiastic members[v] met monthly to create comprehensive background, financial, strategic and promotional materials, including glossy brochures designed *gratis* by the advertising agency Geoff Cousins chaired: George Patterson Advertising.[6]

Cousins and Mather recalled 'making do' with whatever space they could 'squeeze' from the hospital's administrators until new offices, a pain clinic and scientific laboratories were

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[4] Spring, interview.

[5] Spring, interview. Also, Tom Reeve said: 'Michael was better at getting money, well, his brother Geoff Cousins taught him, I think. He understood the money better and I don't think it endeared him to his colleagues. When all's said and done, they were all after the same pot of money. If one person got a bit extra, that's taking it away from the others.' Reeve, interview.

[6] MJC, 'Minutes of Steering Committee Meeting', 2 July 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

constructed. At first, the anaesthesia department occupied an old building, and two 'rather cold and leaky abandoned outpatient treatment rooms' temporarily housed the scientific laboratories. The pain clinic was located on the verandah of an old clinical suite.[7] Fran Boyle, a RNSH oncologist and one of Cousins's early patients, remembers a myriad of exposed colourful pipes overhead rather than a proper ceiling—'an interesting installation!'[8] Despite the somewhat ramshackle accommodation, the mood at the centre was optimistic because the staff shared Cousins's passion for improving pain management.[9] By the end of 1991, new offices, a tutorial room and a clinical research laboratory had been built next to the main operating theatres on level four of RNSH's Main Block.[10]

Michele appreciated the way her husband did not bring his work stress home, even though she and their children could feel his frustration and, sometimes, despair. Chris recalled his father 'took things personally and worried that dealing with uncooperative bureaucrats and colleagues took him away from helping his patients'. Chris remembered his dad struggling through several challenging patches, 'but he battled on because of his conviction that pain management was a fundamental human right'.[11]

Disappointingly, Cousins's first foray into gaining political support for the centre failed when a letter from the New South Wales minister for health service management, Ronald Phillips, arrived. 'I regret that I am unable to offer your Centre the financial support requested', Phillips wrote.[12] Fortunately, by that time, the appeal board was close to finalising its plans. Still, Cousins felt stung by the rejection.

One month later, on 28 September 1991, the appeal board launched its fundraising campaign at a gala dinner at Sydney's Powerhouse Museum. Every anaesthetist in New South Wales was invited, as were government, hospital and university supporters and potential donors. The healthcare company Abbott Australasia sponsored the dinner.

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[7] Mather, 'Stereopharmacological Research in Anaesthesiology', 41.

[8] Boyle, interview.

[9] Mather, interview, 14 April 2019; Allan Molloy, interview by GKD, 3 October 2019.

[10] Editor, 'Pain Management and Research Centre Opens', *Synapse*, no. 165 (June 1994): 1.

[11] Chris Cousins, interview.

[12] Ronald Phillips to MJC, 27 August 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

Cousins commenced his after-dinner speech with a poem by Tom Hornbein, a University of Washington (UW) professor of anaesthesiology. In 1963, Hornbein and a partner climber were the first to ascend Mount Everest via the West Ridge. 'Of all the resources, the most crucial is a man's spirit. Not dulled, nor lulled, supine, secure, replete does man create but out of stern challenge.'[13]

From 7 November 1991, the appeal board met monthly[vi] to progress the fundraising campaign. The minutes of these meetings detail the tortuous process involved in creating comprehensive background materials: a 'case for support'; resumes; testimonials; plans; budgets; a marketing strategy; and promotional materials such as newsletters, videos and brochures. The minutes also reveal progress with building the pain centre and establishing its infrastructure and facilities. Other accomplishments included recruiting personnel and meeting with politicians, bureaucrats, corporations, individual donors and foundations. In addition, board members created lists of prospects, pledges, grants and updates on donations, and Cousins asked his IASP Council colleagues, Bonica, Loeser, Melzack and Wall, to write testimonials supporting the centre.[vii] Within a year, the appeal board had raised its target of $1.3 million.

Meanwhile, Jonathan, Chris and Jane were growing up, and life at home was hectic. Michele acted as the primary disciplinarian because she spent so much time with the children, and Cousins served as the family's peacemaker. Jane recalls that whenever a dispute arose, her father would patiently listen to everyone's point of view, then find a 'fair solution'.[14]

Chris describes his father as a 'warm, loving, calming force' in the household, firm rather than strict. 'Dad taught us values such as being honest, kind and looking after people.' The boys also learned 'olde-worlde manners' from their father, such as pulling out dining chairs and opening car doors for women. If his children had an issue they could not resolve, Cousins would sit with them, draw up a 'pros and cons' list, and suggest how to solve the problem logically. 'Don't sweat the small stuff', was a favourite piece of advice, and whenever his children worked on a project, he told them to 'Remember the Five Ps', the formula for success his father, Hedley, had taught him.[15]

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[13] MJC, 'Appeal for the Anaesthesia and Pain Management Research Centre', newsletter no 2, October 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

[14] Jane Cousins, interview, 6 May 2020.

[15] Chris Cousins, interview.

On weekends, Cousins urged his children to get up and play outside, the way he had done as a child. He had freely roamed through the bush at Killara and spent hours rocketing down the steep hill of his street on a homemade billy cart. One of his favourite sayings was: 'Get up. Get outside. Get some fresh air.' His twins remember he was a 'big believer in exercise and fresh air', considering both to be 'good for the soul'.[16]

Cousins's patient Fran Boyle, who struggled with intense back pain and numb legs after a disc in her lower back prolapsed, consulted orthopaedic surgeon after orthopaedic surgeon, yet none believed her or even offered her pain relief. Fortunately, one of them sent her to RNSH's pain clinic. In the 1990s, going to a pain clinic was seen as a last resort, recalled Boyle; if a surgeon could not fix someone with an operation and the patient still complained of pain, it was 'quite handy' having a pain clinic at the hospital to 'get them out of the surgeon's hair'.

Cousins reassured Boyle, promising to help her reduce the impact of pain in her life. The pain team implemented an interdisciplinary approach, including a carefully graded exercise program and counselling. Cousins injected the anti-inflammatory drug cortisone into her epidural space and prescribed an anti-epileptic medication because of its ability to reduce nerve pain. However, the drug gave Boyle a 'fuzzy head', making it difficult to concentrate, so it was not a sustainable option. Eventually, she found an innovative young neurosurgeon, a 'lateral thinker', who performed a spinal decompression, alleviating her pain.[17]

Another of Cousins's early patients was Jaswir Grewal, who had a twenty-year history of back pain caused by decades of working as a banana grower and motor mechanic. Pain ruled his life and 'took over everything'. Cousins and the interdisciplinary team assessed Jaswir, who was surprised by their suggestion of a morphine pump. The pump provided Jaswir with pain relief, though the morphine triggered unpleasant side effects such as dilated pupils and mood swings. Nevertheless, it reduced his pain and enabled him to 'live a better life', so he accepted its downsides.[18]

One of the medical students who observed Cousins interacting with patients was Marc Russo, who is now a specialist pain medicine physician. Russo remembered Cousins as kind and compassionate with his patients and 'old school'—'that old school professor who was

[16] Chris Cousins, interview; Jane Cousins, interview 6 May 2020.

[17] Boyle, interview.

[18] Jaswir Grewal, interview by GKD, 24 May 2020.

extremely knowledgeable, extremely in command and confident'. Cousins's gentleness with patients impressed Russo. 'That's not something I saw necessarily every day', he remarked, 'especially from many other professors who usually had a retinue of registrars, residents, interns and nurses trailing behind them'. Russo recalled that being on a ward round with some professors was like being at the theatre—'a bit of show, barking commands or whatever to the junior staff, and it would be quite a hurried affair'. Cousins, however, was the opposite. 'During ward rounds, he exuded calmness and confidence and spent a lot of time with his patients.'[19]

Boyle shared this view. As her pain specialist, Cousins was 'very gentle and lovely and explained things well', she remarked. 'Michael was passionate about patient care and training the pain medicine fellows.' In contrast, his behaviour with hospital bureaucrats was commanding, according to Boyle, who was a staff specialist at RNSH. 'He was frustrated with the system and the lack of funding for pain management.' Boyle often observed Cousins challenging the hospital's administrators, especially if 'there was any hint' that his or the pain clinic's activities would be restricted.

Cousins and Boyle both attended meetings of the hospital's drug committee. Boyle recalled that if Cousins requested a medication for a patient, 'he wanted it now', even if the drug had not previously been used in Australia for the purpose he planned to use it. 'By and large, because he was Michael Cousins, people did what he demanded', Boyle stated.[20] The pharmacologist Andrew Somogyi concurred. 'Michael was an absolute world champion in bringing pain medicine, not just to the Australian scene, but also internationally', he remarked. 'He was so well respected that whatever he said, everybody listened to.'[21]

Boyle noted that Cousins was so determined, no-one was prepared to stand in his way. 'It wasn't bullying so much as just being very determined that if a patient needed something that was not on the Pharmaceutical Benefits Scheme or was not part of RNSH's standard protocol for a particular condition, committee members knew Michael had the patient's best interests at heart.' That was what made him so persuasive, Boyle believed, because committee members who knew him understood his goal was providing the best possible patient care. They realised

[19] Russo, interview.

[20] Boyle, interview.

[21] ANZCA, *A Tribute to Michael Cousins*, 6 May 2024, https://youtu.be/QT-dZdq4-cE.

he had the patient's best interests at heart. 'Even though he was ambitious for himself and his pain clinic, his driving force was excellent patient care.'[22]

Meanwhile, the growing demand for pain management services and the centre's rapidly expanding research program quickly raised the need for more clinical staff, space and facilities. Cousins recalled that the centre was understaffed, and team members felt 'continually beleaguered', as though they 'worked on a half-empty tank—sometimes even an empty tank'. Despite these issues, Allan Molloy, who joined the centre as a pain medicine specialist in 1992, said Cousins and his colleagues were immensely caring towards the patients, and the clinic had a convivial atmosphere because everyone shared Cousins's vision.'[23]

As funding improved and laboratory space became available, Cousins prioritised the recruitment of highly qualified scientists and clinicians. As he had done at FMC, he searched the globe for researchers with a keen interest in clinical practice and teaching.[viii] Collaborating with University of Sydney colleagues, he recruited highly respected members of the anatomy and pharmacology departments. He was ecstatic when the highly esteemed neuroscientist Arthur Duggan joined the centre.[ix]

Talented researchers and clinicians were attracted to RNSH's pain centre because it integrated basic and clinical research. While the centre's basic researchers focused on the mechanisms associated with injury to major nerves or the spinal cord, clinical researchers investigated pain after surgery and trauma, cancer pain and chronic pain. Cancer researchers studied treatments for the severe pain often associated with the disease, and chronic pain researchers initially concentrated on spinal cord injury pain and the outcome of various pain management approaches.

In 1992, keen to combine research with clinical care, neurophysiologist Philip Siddall joined RNSH's pain centre. During his job interview, Siddall mentioned his interest in researching nerve pain. Cousins asked him whether he would like to start a research program on spinal cord injury pain.[x] The idea excited Siddall. Shortly after arriving at the hospital, Siddall started a spinal cord injury research program. One day while chatting with David Taylor, another of the

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[22] Boyle, interview.

[23] Molloy, interview.

centre's researchers, they agreed that pain medicine required a consensus about the classification of pain that occurred after spinal cord injury.[24]

Six years earlier, IASP had published *Classification of Chronic Pain: Descriptions of Chronic Pain Syndromes and Definitions of Pain Terms*,[25] one of Bonica's highest priorities for the association. However, the document lacked the level of granularity about spinal cord injury pain the researchers required for prevalence studies and the development of treatments,[26] so Siddall, Taylor and Cousins set to work creating one.[xi]

After completing the classification, the three researchers published an article describing their approach in the influential journal *Spinal Cord*.[27] It resonated with clinicians and researchers worldwide, according to Siddall.[28] Afterwards, the research team pursued several studies on pain after spinal cord injury using this system.[xii]

In mid-1993, Cousins's older brother Keith died after a sudden heart attack. He was sixty-eight. Cousins was once again overwhelmed by grief. He was proud of Keith's accomplishments, and, like Hedley and Geoff Cousins, Keith was one of Australia's advertising titans.[xiii] A consummate networker and powerbroker, Keith tirelessly campaigned to further the interests of Australia's advertising industry. He was also known for his 'old school' insistence of 'looking after the client and ensuring they were happy'.[29]

Eventually, after 'several false starts', a full ward at RNSH was refurbished as a fully functional outpatient pain clinic, and construction began on a suite of research laboratories and offices in the main hospital building. On 9 May 1994, the New South Wales health minister, Ron Phillips, and the University of Sydney's deputy vice-chancellor, Susan Dorsch, officially launched the Centre for Anaesthesia and Pain Management Research (CAPMR). Basic research laboratories were located on level five of RNSH's Main Block, and the main centre, comprising outpatient consulting, minor and major treatment areas, and a fully equipped operating theatre were on

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[24] Philip Siddall, interview by GKD, 1 August 2019.

[25] Harold Merskey, 'Classification of Chronic Pain: Descriptions of Chronic Pain Syndromes and Definitions of Pain Terms', *Pain* (1986): S215–21.

[26] Philip Siddall, interview by GKD.

[27] Philip Siddall, David Taylor and Michael Cousins, 'Classification of Pain Following Spinal Cord Injury', *Spinal Cord* 35 (1997): 69–75.

[28] Philip Siddall, interview by GKD, 1 August 2019.

[29] Crawford and Dickenson, *Behind Glass Doors*, 157.

level nine. A large animal facility containing a fully equipped operating theatre and holding facilities was located on the hospital campus.[30]

Initially, Cousins's laboratory focused on research about the neurophysiology of pain transmission, while Mather's team of scientists studied the pharmacology of analgesics and anaesthetics.[31]

Figure 23: Michael Cousins at RNSH, May 1994.

Courtesy Michael and Michele Cousins.

Figure 24: Ross Harris and Laurie Mather at CAPMR's launch, 9 May 1994.

Courtesy Laurence Mather.

Three months later, on 14 August 1994, Cousins's telephone rang well before dawn. It was Bonica.

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[30] Editor, 'Pain Management and Research Centre Opens', 1.

[31] Mather, 'Stereopharmacological Research in Anaesthesiology', 41.

‘I’m dying, son’, the older man announced, his usually dominant voice sounding soft and shaky.

‘I’ll jump onto the next flight to America to say goodbye to you in person’, Cousins suggested.

‘It’s too late’, Bonica whispered. ‘I will die tomorrow. Michael, my friend, it’s been good knowing you.’

From the day they met in late 1970, Cousins and Bonica had ‘clicked’. Bonica had taken his younger colleague ‘under his wing’, perhaps sensing they were kindred spirits. Driven by their shared passion for reducing patients’ pain, they both worked fiendishly hard to develop effective pain treatments. Bonica’s dominating style—which ‘sent shivers of panic among most colleagues’, according to Jones—did not intimidate Cousins, who ‘stood his ground during disagreements’.[32]

Cousins, who thought of Bonica as his ‘godfather’, believes the pain pioneer’s story is unique. ‘I think in many respects John Bonica was my father in pain management, as he was to many people’, he remarked. ‘Many of the things I have persevered with I’ve done because of his influence. There’s no doubt he gave an extraordinary example of dedication and perseverance, often against insuperable odds.’[33]

Figure 25: John J. Bonica, April 1990.

[32] Jones, interview.

[33] MJC, interview by M. Meldrum, 28.

Courtesy Laurence Mather.

At the time of Bonica's death, Liebeskind was travelling the world conducting oral history interviews with pre-eminent IASP councillors 'to get the story from those who made the story' to ensure it was recorded:

> Maybe we're not unique, but we are at least rare in the annals of the history of science and the history of medicine, of the bringing together of these different kinds of disciplines to focus on a single subject matter. There probably are no other fields that have done so with such great benefit, mutual benefit, to clinical practice and science, and certainly the promise of a lot more.[34]

In a letter Bonica posted to Cousins eight years before his death, he wrote: 'I hope that you and others will continue the work I started some four decades ago.'[35] As one of his mentor's most loyal disciplines, Cousins had every intention of continuing Bonica's quest.

Back at RNSH, one of the pain centre's focus areas was chronic pain. Neuroplasticity research has revealed that the brain and nervous system are constantly changing, and the brain can learn to turn down the volume of pain signals.[xiv] Hence, various techniques, such as pacing, meditation, progressive muscle relaxation and gentle exercise aim to help the nervous system return to normal pain processing so a person living with pain can improve their day-to-day functioning and quality of life.

After ten years of providing Jaswir Grewal with relief from back pain, his morphine pump migrated and was about to break through the skin, forcing Cousins to remove it. Life was challenging for Jaswir without any pain relief.[36] Cousins suggested he take part in an interdisciplinary pain management program that the pain centre's psychologist, Michael Nicholas, had pioneered. Nicholas had joined the centre in 1994 when it still occupied the dilapidated verandah. He had previously developed a four-week inpatient program for people with chronic pain at St Thomas's Hospital in London,[xv] and once RNSH's pain clinic moved to 'Level Nine' of the new tall red building, he introduced a three-week outpatient version of the program he named ADAPT (Active Day-Patient Treatment).[37]

[34] J. Loeser, interview by J. Liebeskind, 13.

[35] JJB to MJC, September 1986, Box 2, Folder 29, Bonica Papers.

[36] Grewal, interview.

[37] Michael Nicholas, interview by GKD, 25 September 2019.

Nicholas recruited the physiotherapist Lois Tonkin, nurse Lee Beeston and clinical psychologist Tim Sharp to run the program. Molloy provided initial medical care for the participants. Early on, Cousins realised the program could not rely on government funding, so he and Nicholas visited workers' compensation companies and the WorkCover Authority of New South Wales seeking financial support. The insurers were eager for injured employees to return to work to reduce compensation payouts, so they provided funding for patients to attend ADAPT.[38]

Cousins also approached foundations and philanthropists, many of whom provided generous support. This funding enabled the program to grow, and Nicholas built up the team to include several physiotherapists, clinical psychologists and nurses. The team members took an interdisciplinary approach, jointly designing a treatment plan for each participant and regularly updating each other on the patient's progress.

ADAPT was based on a cognitive behavioural treatment approach to chronic pain and included education about the underlying mechanisms contributing to pain, carefully graded exercises and training in pain self-management strategies, such as pacing, meditation and flare-up management. It aimed to maximise participants' ability to live well with chronic pain by equipping them with tools to minimise the impact of pain on their lives.[39]

Charmian Frend, who was born with a degenerative disc disease and had endured ten back operations, also found ADAPT immensely beneficial. The first week of the program was challenging, Charmian recalled, because she did not feel ready to have people tell her the pain could not be cured and she had to learn to function despite it. Hearing about the experiences of the other participants surprised her because they matched her own. She had not realised that chronic pain was so commonplace. After completing the program, Charmian stopped grieving for the activities pain prevented her from doing:

> Michael Cousins and the team gave me the certainty I could cope with my pain. I'm not as crippled as I thought I was. I thought I was useless. I now have the assurance that I can put myself out there a bit. I can be of use to someone.[40]

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[38] Nicholas, interview.

[39] Michael Nicholas, Allan Molloy and Lee Beeston, *Manage Your Pain: Practical and Positive Ways of Adapting to Chronic Pain* (London: Souvenir Press, 2012), 76–171.

[40] Charmian Frend, interview by GKD, 11 December 2019.

Symantha Liu, who first met Cousins in the mid-1990s, had lived with chronic neck pain and migraines since the age of five. Cousins offered her several treatment options, including nerve blocks and innovative medications. Symantha appreciated Cousins's approach, which was to treat her with dignity, giving her the courage to keep trying. She was overwhelmed by his kind and caring manner and ability to really 'listen' to her.

Symantha enrolled in ADAPT, finding its communal nature immensely helpful. She valued the support of other participants, who gave her the confidence to persevere during the more confronting moments of the program. ADAPT 'wasn't easy', Symantha recalled, as it challenged her to think about her lifestyle and coping mechanisms in entirely different ways. Through ADAPT, she learned a new coping strategy known as desensitisation—the polar opposite of the 'ignoring pain strategy' she had traditionally used.[41] Desensitisation involves learning not to react to pain negatively. It retrains the way the brain responds to pain, reducing the experience of it.[42]

As mentioned in the Prologue, my own experience with chronic pain introduced me to Cousins in 2005. He trialled a range of medications and, with each one, I brimmed with hope, only to have it dashed when it failed or triggered unpleasant side effects. Kind and caring, he never gave up on me, which I appreciated immensely because so many other specialists had told me they had run out of treatment options. Concurrently, I took part in ADAPT.

ADAPT taught me to stop catastrophising (i.e. having overly alarmist beliefs about pain and underestimating my ability to cope with it[xvi]) and to believe I had the power to change how I reacted to pain. It was life changing. While migraine attacks remain my constant companion, they are now less debilitating and far less frequent because of employing the tools I learned through ADAPT.

Rather than writing for several hours at a time, I now pace myself carefully, limiting my writing sessions to shorter periods of time to prevent a flare-up. I also intersperse writing with gentle stretching exercises and Tai Chi to turn down the volume of pain signals racing through my malfunctioning nervous system. The way I deal with flare-ups is also different. When they

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[41] Symantha Liu, interview by GKD, 19 May 2020.

[42] Nicholas, Molloy and Beeston, *Manage Your Pain*, 169–71.

occur, I practise desensitisation, which has become central to my daily routine, as has meditating every day.

The model of care Cousins advocated through ADAPT and the pain clinic's interdisciplinary approach was a revelation to many general practitioners and pain specialists in Australia—even in the 2000s. Marc Russo feels fortunate to have visited RNSH's pain centre during his specialist training in pain medicine. 'I was taught pain medicine in the era when Michael Cousins and other colleagues around Australia had transformed assessment and care into an interdisciplinary model', he stated. 'Before Michael Cousins introduced interdisciplinary pain management in Australia, we had only tokenistic representation of physiotherapy and psychology.'[43]

Disappointingly, not all people with chronic pain benefit from interdisciplinary pain management programs and some are openly hostile towards the concept, refusing to try it. Molloy admitted that it can be difficult for a person with chronic pain who has been off work and on workers' compensation for an extended period to change from being a passive recipient of health services to one who self-manages their pain. This reaction is especially true if they have tried multiple approaches that have failed to relieve their pain.[44]

Nevertheless, over the years, thousands of people have benefited from interdisciplinary pain management and Cousins fervently believed in its value. 'Interdisciplinary pain management is the gold standard of care for chronic pain', he insisted.

In June 1995, Cousins was appointed a Member of the Order of Australia in recognition of his contributions to establishing interdisciplinary pain management in Australia. The award also acknowledged his research excellence in anaesthesia and pain medicine.[45] He was proud to receive the honour, and his extended family accompanied him to Canberra to receive the medal (see Figure 26).

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[43] Russo, interview.

[44] Molloy, interview.

[45] Australian Government, 'Member of the Order of Australia', Queen's Birthday 1995 Honours List, 12 June 1995, https://honours.pmc.gov.au/honours/awards/883620. 'In recognition of service to medicine, particularly in the fields of pain management and anaesthesia'.

Figure 26: Michael, Jonathan, Michele, Chris and Jane Cousins, Government House, Canberra, 1994.

Courtesy Michael and Michele Cousins.

As well as studying chronic pain, Cousins continued to investigate acute pain and its treatment. 'Poorly managed acute pain can transition to chronic pain, so our team was eager to develop better treatments for acute pain to prevent this from happening', he explained. His RNSH colleague of long-standing, Tom Reeve, was an NHMRC councillor, and the pair often spoke about the need for the Australian Government to take a greater interest in pain management. During 1997, Reeve encouraged Cousins to apply for a position as an NHMRC councillor. 'It was the big table where you can see how things are moving', he remarked. 'I knew it would give Michael an opportunity to be known. He had the background at that point to develop at the scientific level and he was a leader in ideas.'[46] Reeve petitioned the research council, urging it to appoint Cousins.

Reeve also suggested that NHMRC establish a working party to examine the scientific literature on managing acute pain. The council agreed, appointing Cousins as chair soon after he was elected as a councillor. 'I got going straightaway', he recalled. 'I knew it would fill my nights and weekends for many years, but it was an urgent priority, and I felt compelled to do it.' His first step was to invite leading pain management professionals from around Australia to participate in a multidisciplinary working party. He asked the members to study the scientific evidence in their area of expertise. By this time, pain research was thriving, and researchers were feverishly publishing their latest findings. 'The volume of material was overwhelming; it was challenging to keep up with the latest findings', he acknowledged years later.

[46] Reeve, interview.

Another issue concerning him was the tidal wave of opioid prescriptions for chronic pain. This was a controversial practice at the time and remains so today, with America[47] and some other Western nations, including Australia, struggling with an opioid epidemic.[48]

In 1997, the addiction medicine specialist Dr James Bell reported in the *Medical Journal of Australia* that a seventy-three percent increase in the number of authorisations to prescribe opioids for chronic pain had occurred in the previous six years in New South Wales.[49] In an editorial in the same edition of the journal, Molloy, Nicholas and Cousins also disclosed alarming statistics: prescribing of Panadeine Forte, the combination of a regular dose of paracetamol and a high dose of codeine, had escalated from 1.9 million prescriptions at the beginning of the decade to 3.7 million five years later; Panadeine Forte was the second most prescribed drug in Australia. The editorial argued that patients would achieve better outcomes, and governments would make considerable savings, if more funds were invested in interdisciplinary pain management services. It also recommended training to upskill general practitioners and medical specialists, so they referred patients with chronic pain to a specialised pain service rather than prescribing opioids.[50]

Once again, these pleas 'fell on deaf ears', according to Cousins. No-one in political circles heeded their call to invest in interdisciplinary pain management. 'We held grave fears for the consequences of their complacency and inaction', he lamented. 'It made me more resolute than ever to step up my advocacy.'

Believing pain medicine training was 'woefully inadequate', one of his priorities was educating doctors and allied health professionals. From early in his career, he felt compelled to learn from the very best and he treasured the opportunity to learn from Bonica, Wall and Melzack. 'The standards those three pioneers set became my benchmark, and I longed for Australian doctors

[47] M. R. Jones et al., 'A Brief History of the Opioid Epidemic and Strategies for Pain Medicine', *Pain Theory* 7, no. 1 (2018): 13–21; Marcia Meldrum, 'The Ongoing Opioid Prescription Epidemic: Historical Context', *American Journal of Public Health* 106, no. 8 (2016): 1365–66.

[48] AIHW, *National Opioid Pharmacotherapy Statistics Annual Data Collection* (2022), https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics/contents/about.

[49] James Bell, 'Australian Trends in Opioid Prescribing for Chronic Non-Cancer Pain, 1986–1996', *Medical Journal of Australia* 167 (1997): 26–29.

[50] Alan Molloy, Michael Nicholas and Michael Cousins, 'Role of Opioids in Chronic Non-Cancer Pain', *Medical Journal of Australia* 167 (1997): 9–10.

to embrace them', he said. 'I felt a responsibility and deep commitment to share my knowledge and skills.'

Medical students receive little pain education,[51] yet, prior to the COVID-19 pandemic, pain was the number one reason people visited a general practitioner. In 2018, 81,200 Australians visited their general practitioner with a pain-related condition each day.[52] This is expected to increase with the emergence of chronic pain conditions related to 'long COVID'.[xvii]

In the early 1990s, Mather had suggested introducing an interdisciplinary teaching program the team 'could take on the road' and, for four years, the pain centre's staff offered educational roadshows around New South Wales.[53] Later, when the former Flinders psychologist Ross Harris joined the team, they incorporated the roadshow content into a graduate diploma and a master's degree in pain medicine at the University of Sydney.[54] The first twenty-eight students started in 1996, with the two-year part-time course attracting a diverse range of doctors and allied health professionals. Initially, the course instructors mailed video cassette tapes and accompanying bundles of notes to students unable to attend lectures in person, eventually progressing to teleconferencing and, later, the internet, to offer pain management courses across Australia and overseas to doctors, nurses and allied health professionals, often in partnership with international universities.[55]

Milana Votrubec, a general practitioner, was in the first cohort of students to complete the master in pain medicine. Cousins's commitment to finding better ways of managing pain inspired Votrubec to do the same. She particularly valued the way he encouraged her to find answers to the many questions she raised. 'Think of the question, and then think about an action', he would advise. 'Go and research it, because it will probably stick far better if you've looked it up yourself.' Votrubec found it a refreshing way to learn compared to medical school,

[51] Elizabeth Devonshire, interview by GKD, 20 September 2021.

[52] AIHW, *Australia's Health 2018,* 18 June 2019, https://www.aihw.gov.au/getmedia/7c42913d-295f-4bc9-9c24-4e44eff4a04a/aihw-aus-221.pdf.

[53] Mather, interview by GKD, 29 April 2019.

[54] Harris, interview.

[55] 'In Profile: Professor Ross Harris', *Northern Clinical School Newsletter*, 2001, Laurence Mather Private Collection; Devonshire, interview. By 2009, students from twenty countries had completed this program. MJC, 'History of Pain Management'.

where she had been 'taught by being told', soaking up information like a sponge rather than finding it out for herself.[56]

On weekends, Chris Cousins enjoyed watching his father rehearse his lectures, recalling:

> Dad would have two slide carousels so he could put an image on one screen and his teaching materials on the other screen. I think it's an example of how he'd go to the nth degree to make sure complicated concepts were translatable and easy to understand. He nurtured his students and would go to the earth's ends to help other people learn about pain medicine.[57]

During his training, the pain specialist Tim Tucker appreciated the way Cousins simplified complex concepts so they were understandable. 'Michael spent a lot of time teaching a new generation', Tucker said.[58]

Sharing dinner with his family continued to be a priority for Cousins, and Jane remembered lively conversations around the dining table. Always the diplomat, her father steered dinner conversations away from party politics[xviii] and instead centred on issues such as free speech, human rights and 'bigger picture topics'.[59] Sometimes he mentioned his daily battles with hospital administrators; however, Chris insisted that his dad did not use the dinner table as a forum to vent his frustration.[60]

Life remained busy in the Cousins's household as Jonathan and the twins navigated through their teenage years. James returned home for six months to study, delighting his parents and siblings. Believing in the value of competing in team sports to learn leadership and collaborative skills, Michele and her husband encouraged their children's sporting endeavours. They dedicated many weekends to cheering Jane from the sidelines when she played hockey, and, as a proud 'Shore Boy' himself, Cousins relished the opportunity to watch Jonathan and Chris represent Shore in rugby and rowing. 'Dad would give us some advice', Chris recounted, 'but ultimately, he wasn't trying to achieve anything through his kids'. Chris often noticed how

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[56] Milana Votrubec, interview by GKD, 30 April 2019.

[57] Chris Cousins, interview.

[58] ANZCA, *A Tribute to Michael Cousins*.

[59] Jane Cousins, interview, 6 May 2020.

[60] Chris Cousins, interview.

'measured, level-headed and straightforward' his father was when other parents were 'hurling abuse at the referee or yelling instructions to their sons from the sidelines'.[61]

Some weekends, Cousins helped Jane prepare for her debating competitions. 'Dad loved quotations and couldn't get enough of them', she said. 'We enjoyed getting stuck into a book of quotations together. His witty sense of humour often helped me shape my arguments, and he was always happy to listen while I practised my speeches.'[62]

This sense of humour emerged in childhood when he told 'terrible jokes' and orchestrated elaborate pranks, according to his brother Geoff and childhood friends.[63] However, in professional situations his humour was more subtle; it also varied with different people. For example, while O'Grady recalled him as always serious and rarely laughing, Knights, Gourlay and Mather said he had a dry sense of humour—rather than cracking jokes, he made subtle, wry remarks. Harris described Cousins's sense of humour as 'surprising'.

In meetings, Harris observed how Cousins remained focused on the 'items of business' and 'getting passage of each agenda item' in a serious, logical manner. Yet, when someone said something silly or told a joke, he paused, enabling everyone to experience a light moment, 'a little sugar to the mixture', that enabled team members to 'come to terms with difficult problems' and reduce the pressure in the room. 'Michael was the master of managing the tone of a meeting', Harris stated, 'grinding through challenging agendas but sensing when it needed to lighten up for a moment to take the pressure off us'.

When debates and disagreements occurred in meetings, Harris appreciated how Cousins handled them with equanimity. 'I don't think there's one time I can recall anyone feeling they were being hammered at a personal level', he said. 'The focus was on the options for solving a problem then mapping out the steps required to resolve it.' Cousins's approach to problem-solving in meetings was resolute and reasonable. 'If we want to get any sleep tonight fellas, we've got to deal with this', he said when faced with an impasse. 'We need to put our minds

[61] Chris Cousins, interview.

[62] Jane Cousins, interview, 6 May 2020.

[63] Ryan, interview; Chapman, interview; Geoff Cousins, interview by GKD, 24 September 2019.

to it.' This motivated team members to find a solution because they knew the meeting would continue until 'we had clearance on whatever matters were on the table'.[64]

In 1997, Cousins felt honoured when the American Society of Anaesthesiologists invited him to present its annual oration in San Diego. With Michele in the audience, he decided to 'go out on a limb' in his address, introducing two concepts—pain relief as a universal human right and chronic pain as a disease in its own right. At the beginning of the lecture, he recounted a chilling description of chronic pain written by the psychologist Lawrence LeShan:

> Terrible things being done, worse threatened.
> Outside forces in control. Will is helpless.
> No time limit set. Cannot predict when it will end.
> Pain is alien and meaningless. Consciousness turned inward. Time perspective lost.
> Relationships weakened.[65]

Inviting the audience to 'climb into the skin' of a patient with severe unrelenting pain, he asked the delegates, mainly anaesthetists: 'What does LeShan's account of chronic pain suggest to you?' Then he answered this rhetorical question: 'We must improve the way we treat chronic pain and change medical attitudes towards it.'[66] Lamenting the lack of government focus on chronic pain and its unacceptable human and economic costs, he insisted that societal attitudes towards people with chronic pain must change:

> Chronic pain is the silent epidemic. Patients with chronic pain often suffer silently. Relatives and others are silent; they hope it won't happen to them. Society is silent; mostly, it's unaware of the enormous human and financial cost. Politicians are silent because the costs are overwhelming. A huge gap exists between knowledge and practice, and this gap is widening as knowledge increases exponentially.

Cousins concluded the first part of his lecture by declaring: 'The plight of patients with chronic pain points to the need for a unique approach, one viewing pain relief as a basic human right. Everyone has a right to access pain management services.' Asserting that it was up to pain professionals to take this concept to the community at large, he warned his audience it would be a 'tough call' to change medical and societal attitudes.

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[64] Harris, interview.

[65] Lawrence LeShan, 'The World of the Patient in Severe Pain of Long Duration', *Journal of Chronic Diseases,* 17, no. 2 (February 1964): 119.

[66] Michael Cousins, 'Pain: The Past, Present and Future of Anesthesiology? The E.A. Rovenstine Memorial Lecture', *Anesthesiology* 91 (1999): 540.

To some audience members, equating the right to pain management with human rights such as freedom from hunger was provocative. His claim raised their hackles, an early indication of the opposition he would later face in pursuing this concept. Nonetheless, his enormous self-confidence gave him the courage to take a moral stand despite this resistance, and he encouraged his colleagues to take the lead in the larger debate that pain management was a fundamental human right. 'We would want nothing less for ourselves and certainly for our loved ones', he added.[67]

The second theme of his lecture was one the early twentieth-century French surgeon René Leriche proposed, namely that chronic pain was no longer seen as a symptom but as a *douleur-maladie*, a pain disease.[68] Leriche's theory that chronic pain was a disease in its own right was sometimes considered by the medical profession; however, it did not gain legitimacy as a theory, if at all, before 1953 when Bonica invoked it in *The Management of Pain*.[69]

Cousins painstakingly described the emerging evidence that chronic pain could cause persistent physical effects within the nervous system: 'Pain receptors in the body can become sensitised by surgery or trauma, increasing the body's response to any noxious stimulus in the area of the pain.' He felt a shiver ripple through the audience. This was the beginning of his crusade to have chronic pain recognised as a chronic disease. His claim was an explicit challenge to the prevailing orthodoxy that pain was merely a symptom of an underlying injury or illness. It was a controversial position to take and divided the pain medicine community. Unperturbed, he persisted in the face of strident criticism.

Such censure was not new to him. Throughout the 1990s, he had felt increasingly 'run down' by the relentless demands on his time and his frequent battles with the hospital's managers about funding, facilities and staffing. He left home at six thirty each morning, even earlier on the days he conducted surgical procedures, and he rarely arrived home in the evening before seven o'clock. After dinner, he usually headed to his study for several more hours of work.

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[67] Cousins, 'Pain: The Past, Present and Future', 551.

[68] René Leriche, *The Surgery of Pain* (Baltimore: Williams & Wilkins, 1939), 186.

[69] Bonica, *The Management of Pain*, 11–17.

Figure 27: Michael Cousins during a pain management procedure, RNSH, 1990s.

Courtesy Michael and Michele Cousins.

One weekend, some of Cousins's friends at Palm Beach Surf Club encouraged him to take up the surf ski. The following weekend, he bought one and started training with his friends. Within a year, he had mastered the sport, even in monstrous surf, and he competed in 'friendly' surf club competitions. This sport, he believed, gave him a 'second lease of life'; it was a 'godsend'. It also provided an outlet for him to tune out from his worries.

One of his concerns was the acute lack of space at the pain centre. Existing facilities were inadequate to cope with the centre's surging patient load, research programs and educational initiatives. Once again, he petitioned the appeal board to raise more funds. It did not take long for it to secure $6 million from the business community and general public.[xix] 'It came down to the public, rather than governments, to identify pain management as a priority area and to build an integrated pain centre', he sighed.

As the end of the twentieth century approached, he reflected on the pain centre's achievements. Pleased that its research had improved several areas of pain management—spinal cord injury, cancer, acute and chronic pain—he was nevertheless impatient and longed to make deeper inroads into unravelling the puzzle of pain. The centre's ballooning budget continually burdened him, and despite his constant badgering, he failed to secure the funds he requested from the hospital's administrators.

In 1997, Cousins lamented the pain centre's financial constraints in conversations with fellow NHMRC councillors. They suggested he apply to NHMRC to appoint the pain centre as a

‘Centre of Excellence’. If successful, the centre would be assured of five years of funding to fast-track its research. Mather and Cousins set to work, drafting an exhaustive submission, though they sensed the chances of success were slim.[xx]

After months of anxious waiting, they were euphoric when a letter arrived on 20 November 1997[70] informing them that the pain centre’s application had been successful. It included an annual grant of $180,000.[xxi] At around this time, the pain centre board renamed the research arm the Pain Management Research Institute (PMRI) and the hospital named the pain clinic the Pain Management Research Centre (PMRC).[71]

Another source of anxiety for Cousins was insufficient pain medicine training. For many years, he had urged the Australian and New Zealand College of Anaesthetists (ANZCA), which trained specialist anaesthetists, to set up a pain medicine training program. Much to his delight, in the mid-1990s, ANZCA introduced a certificate in pain management for anaesthetists.[72] This program had similar content to the diploma and master’s courses the RNSH pain team had introduced at the University of Sydney, but it specialised in anaesthesiology rather than being multidisciplinary.[xxii]

Shortly afterwards, Cousins contacted the leaders of five specialist medical colleges representing anaesthetists, surgeons, physicians, psychiatrists and rehabilitation specialists to suggest they form a joint advisory committee on pain medicine.[73] ‘To my surprise, they all agreed, and we soon started our work’, he recalled. ‘I wanted to create a joint pain management training program for medical specialists.’

Yet it would be a torturous process, as he well understood. ‘I knew trying to bring several medical specialties together to create a joint training program was a tough ask’, he admitted, ‘because of professional jealousies, vested interests and historic turf wars’. Pressing ahead, the concept gradually gained traction. Fortunately, he knew several senior people within each medical college, and he had a ‘secret weapon’: ‘I kept a file card with the name and mobile phone number of the people heading each specialist college’, he grinned. ‘It sat on the

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[70] David Clarkson to MJC, 18 November 1997, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 3.

[71] Mather, interview by GKD, 16 April 2019.

[72] E. A. Shipton et al., ‘Commentary. The Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists—History and Strategic Plan’, *Pain Medicine* 15, no. 12 (December 2014): 1992–95.

[73] Shipton et al., ‘Commentary’, 1992–95.

dashboard of my car. Every night while driving home, I would call the college leaders, working down the list then back around again.'

In these conversations, he briefed the college leaders about what he was doing, reassuring them he would provide regular updates about progress. Urging them to put aside their differences, he encouraged them to focus on broader objectives—improving pain medicine treatment, education and training.

In March 1998, following months of intense debate, the two ANZCA committees Cousins chaired unanimously agreed to set up a Faculty of Pain Medicine (FPM) to administer a single training and accreditation process for pain specialists. The involvement of five specialist colleges was in keeping with the interdisciplinary nature of pain management services. The committees submitted a proposal to ANZCA's leaders for approval.[74]

Three months later, on 12 June 1998, the ANZCA Council met for a full day at the Melbourne Club[xxiii] to review the pain committee's proposal. By that stage, Cousins 'had a few people onside, but not that many', so he did not know if he had the numbers 'to get the proposal over the line. It was touch and go.'

At the meeting, Cousins fielded several heated objections. One council member remarked: 'Well, it's all very well, but I think it should just go around a few more times to let it mature a bit.' Richard Walsh, ANZCA's president, disagreed with this demand, and the council members trawled through the proposal 'line by line, page by page'.[xxiv] Much to Cousins's surprise, at the end of an exhausting day of negotiating, the council approved the proposal. He was ecstatic. 'It took good running shoes to get the Faculty of Pain Medicine off the ground. No-one thought we could do it.' The pain specialist Tony Weaver said the debate that day was just one example of Cousins's legendary ability to 'take control of the room' at ANZCA meetings.[75]

The agreement to run a joint training program, examination and specialist qualification for medical specialists was unique anywhere in the medical world. Walsh and Cousins wrote to the presidents of the five specialist colleges asking them to nominate a member for the faculty's board.[xxv] On 23 November 1998, the board members conducted their first meeting by

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[74] Shipton et al., 'Commentary', 1992–95.

[75] ANZCA, *A Tribute to Michael Cousins*.

teleconference, and Cousins accepted their invitation to serve as FPM dean.[76] He was relieved the teleconference proceeded smoothly because he was due to travel to Boston for the wedding of his oldest son, James, one week later and he did not want to leave faculty matters 'up in the air' while he was in America holidaying with his family.

After the summer holidays, on 4 February 1999, he participated in the first face-to-face meeting of FPM's board. 'It was a historic day for pain medicine in Australia and New Zealand', he wrote in the *ANZCA Bulletin*. 'It marked the beginning of specialist pain medicine training and heralded a unique level of professionalism in pain medicine.'[77]

Roger Goucke, who served as head of pain medicine at the Sir Charles Gairdner Hospital in Perth for twenty years, said everyone thought setting up FPM was an excellent idea, 'however, it seemed like an impossible dream'. Goucke said launching the faculty was the only way Australia could advance pain medicine practice. 'Michael Cousins recognised that if the nation had a respectable, well-organised professional body, pain would have a higher profile within medical circles and government.'[78]

Looking back on those years, Carolyn Arnold, the first female president of the Australian Pain Society (APS) and, later, an FPM board member, believed most pain medicine professionals felt isolated before the faculty formed. 'The Faculty of Pain Medicine quickly brought everyone together. To some extent, pain clinics were full of disappointed patients who'd failed other treatments. Many doctors felt a sense of hopelessness about working in a pain clinic.'[79]

Pam Macintyre, director of the acute pain service at Royal Adelaide Hospital and a member of the faculty's inaugural board, concurred, stating that before FPM was established, many in the pain medicine community were naysayers and thought a joint training program would not work. She admitted that Cousins put some colleagues offside by being single-minded and driving his own agenda rather than being truly consultative; however, without a declarative approach, the faculty would not exist. 'Over the years, Michael Cousins had his detractors who

[76] MJC, 'Faculty of Pain Medicine: Dean's Message', *ANZCA Bulletin* 8, no. 4 (March 1999): 57–58.

[77] MJC, 'Faculty of Pain Medicine: Dean's Message', *ANZCA Bulletin* 8, no. 4 (March 1999): 57.

[78] Roger Goucke, interview by GKD, 23 October 2019.

[79] Carolyn Arnold, interview by GKD, 9 October 2019.

thought he was too big for his boots and self-promoting, but he was the one with the get-up-and-go. He got things going.'[80]

Concomitantly, Cousins continued his crusade to convince the scientific and medical worlds that pain relief was a fundamental human right. He had a 'hunch' that the more medical professionals and scientists acknowledged the human rights angle as a valid concept, the more it would appear to be a unanimous opinion from medical experts. Once it gained currency, he sensed the next step would be to garner the support of respected community members in philosophy and the arts as well as lawmakers and legislators. His aim was for community leaders to embrace the idea, 'put their weight behind it' and discuss it persuasively within their circles and the mainstream media. As the concept gained traction, he hoped thought leaders and the media would pressure governments to prioritise pain management and fund it at the required level. Acknowledging it was an ambitious long-term goal, he resolved to put his plan into action.

In July 1999, NHMRC's working party on acute pain management finalised its guidelines, and the Australian Government published *Acute Pain Management: Scientific Evidence*.[81] This document would become a watershed resource internationally.[xxvi] It attracted an avalanche of media coverage and, as the spokesperson for the working party, Cousins was 'run off his feet' doing media interviews. Access to pain management was a fundamental human right, he declared, and medical professionals must properly treat acute pain to prevent it from transitioning to chronic pain.

As well as educating the general public about pain, he longed for his media commentary to reduce the stigma associated with chronic pain. 'People with chronic pain fear others will perceive them as a malingerer or hypochondriac', he told journalists. 'It's a silent epidemic because the people who live with chronic pain day after day, year after year are too afraid to speak about it.'[82]

A few months later, he updated his anaesthesia colleagues about FPM's progress. In the November 1999 *ANZCA Bulletin*, he wrote that several pain centres around Australia had

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[80] Pam Macintyre, interview by GKD, 3 October 2019.

[81] NHMRC, *Acute Pain Management: Scientific Evidence* (Canberra: Commonwealth of Australia, 1999).

[82] 'Pain Relief Cost Effective and a Basic Human Right', *AAP,* 12 July 1999; Sean Parnell, 'The Relief of Severe Pain Was a Basic Human Right', *Courier Mail*, 15 July 1999; Darren Gray, 'The Cost of Pain Hurts the Nation's Economy', *Age,* 13 July 1999.

applied for accreditation as approved training centres for pain specialists, noting that hospital administrators often corrected deficiencies immediately to ensure the faculty accredited its pain centre. In the update, Cousins thanked the board for its tremendous work, concluding that the faculty's achievements in 1999—the first year of its existence—were significant.[83]

Back at PMRI and PMRC, talented pain specialists and scientists from Australia and across the globe competed to join the team because of its integrated scientific research and clinical care. The paediatric pain specialist Suellen Walker valued the opportunity to combine patient treatment in the pain clinic and scientific experiments in the institute's laboratory. She felt privileged to have the chance to link her laboratory studies and clinical care and 'be able to take clinical questions back to the lab, and vice versa'.[84]

Chris Vaughan, PMRI's head of basic research, concurred. He admired how Cousins encouraged the basic scientists to visit the pain clinic to help them better understand the nature and impact of pain conditions. After listening to patients describing their experiences and hearing Cousins's explanations in 'layman's language', Vaughan changed his research focus to studying nerve pain.[85]

Walker also enrolled in the centre's master's degree. She appreciated how the course brought together professionals from across several disciplines because they could share their differing perspectives. The number of overseas doctors who travelled to Sydney to study with Cousins also impressed her. Many of them returned home to be trailblazers, taking up leadership positions in pain centres around the world.[86]

Cousins continually searched for talented staff and if he thought a team member was 'on board and committed', he invested time and energy in mentoring them.[87] Mather said Cousins had a reputation for 'being a superb judge of people's skills and capacity and putting the right people in the right job'. He was also adept at managing teams of highly skilled professionals. Appointing accomplished people to senior positions, he delegated challenging projects to them, empowering them to 'get the job done'. During their four-decades long partnership, Mather

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[83] MJC, 'Faculty of Pain Medicine: Dean's Message', *ANZCA Bulletin* 8, no. 4 (March 1999): 57.

[84] Suellen Walker, interview by GKD, 27 August 2019.

[85] Chris Vaughan, interview by GKD, 20 August 2019.

[86] Walker, interview; Brenda Lau, interview by GKD, 25 August 2019.

[87] Charles Brooker, interview by GKD, 13 August 2019.

witnessed Cousins leading by example. 'Michael had enormous expectations, and got the best out of people', Mather recalled. 'He inspired his colleagues to achieve things they never thought they could accomplish, though some colleagues found him far too demanding.'[88]

Colleagues recalled Cousins's distinctive way of starting a telephone conversation when he 'asked' them to take on a project. David Scott, an ANZCA colleague, recounted the phone call when Cousins 'invited' him to set up the cardiovascular anaesthesia taskforce:

> David, thank you for taking the time to talk with me. I wanted to talk with you about something I've given a lot of thought to, and I think is quite important. We need really expert and capable people to lead each task force. You are the perfect person to lead the cardiovascular anaesthesia task force. I would very much appreciate you taking this on. Would you be able to help me?[89]

Several colleagues admitted that Cousins was slow to act when addressing conflict between team members. Also, rather than counselling underperforming team members—someone who attracted insufficient research grants or did not publish enough scientific papers—he would let them 'dangle on the tree' until they realised their only option was to resign. In contrast, he would not step back when the conflict involved administrative roadblocks or something he wanted to achieve for the pain centre. His habit of charging straight ahead or going around the obstacle was legendary and served him well.[90]

Over a period of fifty years, Reeve 'observed Michael from the sidelines'. Cousins's distinctive modus operandi intrigued him. 'Michael was a bit of a loner and his family developed around him', Reeve remarked. 'He was good with his mother, father and Michele; he was a much stronger centre to his family than many other men. And that's how he worked in his pain clinic. It was how his team related to him, not him to them as much.'

Reeve admitted that some people criticised Cousins for keeping all the research within his team rather than working collaboratively with other research groups.[91] Perhaps that is why Cousins had tense relationships with some of his peers, especially those from major teaching hospitals across Sydney. One of these acquaintances declined an interview request, claiming Cousins was driven by self-interest. 'I have nothing more to say', he wrote in an email. Another peer

[88] Mather, interview, 16 April 2019.

[89] David Scott to GKD, personal communication, 10 May 2024.

[90] Brooker, interview.

[91] Reeve, interview.

was more gracious despite a strained relationship with Cousins. 'With Michael, it was a matter of doing it himself so he could get all the ideas from it to progress a project', Reeve attested. 'Some people are like that. They have to work their way and advance things. He was clearly effective. Otherwise, he wouldn't have been involved in so many things at others' requests.'[92]

By the end of the century, the international pain medicine community regarded PMRI and PMRC as world leaders in pain research and patient treatment.[93] Yet Cousins often felt 'at his wit's end' because of financial constraints and what he claimed was hospital mismanagement. A decade later, after reviewing acute care services in New South Wales public hospitals, the Garling Commission would share this concern.[xxvii]

The year 1999 was pivotal for Cousins. He celebrated his sixtieth birthday and thirty-five years since he had decided to specialise in pain medicine. Jane and Chris also completed their last year of school. One incident that year affected Chris deeply. It was the eve of his final 'Head of the River' rowing regatta, and Shore's tradition was to hold a 'Telegram Night' at its boatshed. Rather than faxing the usual 'rallying cry' or 'win at all costs' type of message, Chris recalled his dad sent Rudyard Kipling's poem 'If'.[94] Kipling wrote the poem in 1895 as paternal advice to his young son. Chris felt the poem typified his father's 'gentlemanly approach to sportsmanship and competition', in that he encouraged him to give the race 'every last ounce of energy and sinew', rather than insisting he must try to win.[95]

Many nights and weekends, Cousins, Mather and their colleagues laboured over funding applications. During the 1990s, from dozens of competitive research grant applications to NHMRC, thirty-two were successful, securing the centre over $5 million.[96] In February 1999, Mather received a letter from Cousins acknowledging his 'Herculean efforts' and the personal time he dedicated to securing so much NHMRC funding.[97]

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[92] Reeve, interview.

[93] Loeser, interview, 28 September 2019; Alan Basbaum, interview by GKD, 19 December 2019; Rollin Gallagher, interview by GKD, 19 September 2019; Tony Yaksh, interview by GKD, 25 September 2019; Dan Carr, interview by GKD, 18 July 2019.

[94] Rudyard Kipling, 'If', Poetry Foundation, accessed 6 June 2023, https://www.poetryfoundation.org/poems/46473/if.

[95] Chris Cousins, interview.

[96] MJC, 'Curriculum Vitae: Professor Michael Cousins AO', 7–14; Mather, 'Stereopharmacological Research in Anaesthesiology', 22–23.

[97] MJC to L. Mather, 24 February 1999, Laurence Mather Private Collection.

Applying for grants was arduous and time-consuming, and Cousins resented that it soaked up so much of his leisure time. Still, everyone at PMRI accepted it was a crucial part of sustaining academic endeavours. In 2001, Mather wrote at the bottom of his performance review: 'Feeling of frustration that so much of my time and effort has to be put into fundraising activities.'[98]

Brian Davidson, who chaired PMRI's fundraising organisation, the Pain Foundation, disclosed that the centre focused on building long-term relationships with foundations and corporations rather than trying to attract donations from the general public. He recognised that one of Cousins's many strengths was his ability to 'open doors' for fundraising because of his high profile and knack of communicating a simple message to donors. As Davidson listened to Cousins talking to people about the plight of patients with chronic pain, he noticed how the stories resonated with those in the room.[99] Fran Boyle attended several fundraising events and observed how Cousins expertly 'worked the room'. Noting his persona with donors, she said he was 'quite the affable professor'. In these situations, Boyle saw no hint of the formidable negotiator apparent in meetings with hospital bureaucrats and anyone who threatened his ability to achieve his goals.[100]

Peter Kam, the Nuffield Professor of Anaesthetics at the University of Sydney, noted that Cousins exuded enthusiasm and confidence and was persuasive, overcoming the medical profession's resistance to change.[101] Roger Goucke claimed that, in the early days, Cousins was the only person in Australia to have the right character and 'inexhaustible enthusiasm' needed to raise the enormous sums of money, personnel and real estate required to set up two world-class pain centres.[102] Charles Brooker, who joined RNSH's pain centre in the early 1990s, agreed. He admired Cousins's fundraising ability,[xxviii] though he felt daunted by the sheer number of projects his mentor juggled. Brooker revealed that, like many pioneers and leaders, Cousins did not dot the 'i's and cross the 't's. 'Instead, he came up with an idea,

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[98] L. Mather and MJC, 'Performance Management and Development Annual Evaluation: Review Laurie Mather', July 2001, Laurence Mather Private Collection.

[99] Brian Davidson, interview by GKD, 23 July 2019.

[100] Boyle, interview.

[101] Peter Kam, 'Honouring a Giant in the Field of Pain Medicine: An Anaesthesia Perspective', *ANZCA Bulletin*, 25, no. 4 (December 2016): 80–84.

[102] Goucke, interview.

kickstarted the project, secured funding and surrounded himself with highly competent people who would look after the finer details.'[103]

Brooker respected the way Cousins was so forward thinking:

> Michael was always thinking ahead, focused on the next step and the next step after that. But this meant he was exhausting to work with, always setting the pace. Whenever the team had a small win, rather than celebrating, he had a habit of saying: 'Oh, well, that's great, now what about this?'

Brooker recalled some colleagues felt Cousins was leaving all the research and clinical care to others while he pursued FPM, ANZCA and IASP projects, yet 'most knew Michael was hard at it himself'.[104]

By the end of the twentieth century, Cousins felt immensely proud of the pain centre's achievements, though he was impatient for it to keep making progress. Looking forward to the new millennium, he mapped out ambitious plans to further advance the field of pain medicine in Australia. One accomplishment that particularly pleased him was the centre's advancement of pain management on so many fronts and that these techniques were filtering through to clinical practice. PMRI and PMRC had helped thousands of people live better lives, and he was determined to improve access to pain management services in the coming years. However, given continuing funding shortfalls and systemic inertia, it remained to be seen whether this would be possible.

[103] Brooker, interview.

[104] Brooker, interview.

Chapter Ten: The 2000s

As the new century dawned, Cousins worried that pain management was still not on the national agenda. Nor was it high in the awareness of Australia's state governments, which meant it was chronically underfunded.[1] At every opportunity, he urged politicians, bureaucrats and hospital administrators to focus on pain and its management.[i] Most ignored his arguments, and some were openly hostile towards him. An added concern was that most people misunderstood chronic pain. 'To some extent, chronic pain has a rather cruel and unfortunate label', he explained. 'People with lower back pain are sometimes characterised in a very condescending manner, and this goes back a long way, even to cartoons in former eras.'

Though he knew it was essential to 'kickstart a community conversation', Cousins recognised this would not be straightforward. The linchpin, he thought, would be collecting data on the magnitude of the pain problem and then recruiting several high-profile individuals to talk about the issue.

He spoke with the pain centre's epidemiologist, Fiona Blyth, about his idea. She shared his vision because of her growing understanding of chronic pain as a significant public health problem. They agreed that Blyth would analyse data from government health surveys to estimate the prevalence and cost of chronic pain. Blyth based one of her first studies on data from the New South Wales Health Department's first statewide adult health survey, evaluating over 17,000 responses. The findings astonished her: fifteen percent of men and twenty percent of women lived with chronic pain.[2]

Armed with these statistics, Cousins met with politicians and bureaucrats to encourage them to increase the funding of pain management services around Australia to meet soaring demand. Ever the agitator, he urged his colleagues to do the same.[3]

Meanwhile, the board of the Faculty of Pain Medicine (FPM) continued to forge ahead, developing a curriculum to support training and accrediting several pain clinics throughout Australia and New Zealand. The faculty's education committee, under the leadership of Milton

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[1] MJC, 'Faculty of Pain Medicine: Dean's Message', *ANZCA Bulletin* 9, no. 3 (August 2000): 43–45.

[2] Fiona Blyth et al., 'Chronic Pain in Australia: A Prevalence Study', *Pain* 89 (2001): 127–34.

[3] MJC, 'Faculty of Pain Medicine: Dean's Message', *ANZCA Bulletin* 8, no. 3 (August 1999): 24.

Cohen, a specialist pain medicine physician and rheumatologist at Sydney's St Vincent's Hospital, took great strides. The curriculum was rigorous, preparing staff in pain centres to assess and treat the multiple aspects of pain.[4]

Pain medicine would achieve greater prominence and priority, Cousins wrote in the *ANZCA Bulletin*, if viewed as a specialist area of medical practice rather than as a subspecialty of anaesthesia. This statement heralded the launch of his next endeavour, which was to lobby the Australian Medical Council (AMC) to recognise pain medicine as a specialty in its own right.[5] Goucke and Cousins set to work to assemble the exhaustive evidence required by the council.[6]

In 2002, after completing his three-year term, Cousins stepped down as FPM's dean. By then, the faculty truly embodied an interdisciplinary approach to pain medicine. The new dean, Leigh Atkinson, was a neurosurgeon and the vice dean, Milton Cohen, a rheumatologist. The examination committee chair, Penny Briscoe, was an anaesthetist, and several psychiatrists and rehabilitation specialists served on the board and committees.[7]

On top of his hospital commitments, Cousins maintained a heavy schedule of speeches in Australia and overseas. In 2002, he felt honoured when the European Society of Regional Anaesthesia awarded him the Carl Koller Gold Medal for his contributions to the field of regional anaesthesia. An aspect of this award was presenting the society's prestigious oration in Barcelona at its first world congress on regional anaesthesia and pain therapy.[8] It was a tremendous opportunity, he thought, to explore the future of spinal analgesia.[9] He also presented papers on the transition from acute to chronic pain and methods of preventing it,[10]

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[4] MJC, 'Faculty of Pain Medicine: Dean's Message', *ANZCA Bulletin* 9, no. 1 (March 2000): 37.

[5] MJC, 'Faculty of Pain Medicine: Dean's Message', *ANZCA Bulletin* 9, no. 3 (August 2000): 43.

[6] Goucke, interview.

[7] MJC, 'Faculty of Pain Medicine: Dean's Message', *ANZCA Bulletin* 11, no. 1 (March 2002): 47.

[8] André A. J. van Zundert and John A. W. Wildsmith, 'The European Society of Regional Anaesthesia and Pain Therapy (1982–2012): 30 Years Strong', *Regional Anesthesia & Pain Medicine* 38, no. 5 (2013): 439.

[9] Michael Cousins, 'Carl Koller Gold Medal Oration, Spinal Route of Analgesics: Current and Future Options', World Congress on Regional Anaesthesia & Pain Therapy, Barcelona, Spain, June 2002, MJC Private Collection.

[10] Michael Cousins, 'Progression from Acute to Chronic Pain: Future Perspectives', World Congress on Regional Anaesthesia & Pain Therapy, Barcelona, Spain, June 2022, MJC Private Collection.

acute pain services in Australia[11] and the centre's spinal cord injury pain research.[12] Michele accompanied him to Barcelona, so, after the congress, they enjoyed exploring the Spanish city together.

The following year, the couple bought an old house with a spectacular view of Palm Beach and Barrenjoey. They had dreamed of buying a holiday house there for the previous decade but had not been able to afford it. Once they settled in, it became a refuge for Cousins, who, at sixty-four, still worked at his desk until late each night. By then, in partnership with several colleagues, he had published 208 papers, steadily logging a published paper every eight weeks for thirty-two years.[13]

From then on, the family stayed at Palm Beach every weekend, though Cousins spent the bulk of his time 'holed up in the study'. Fortunately, he always 'squeezed in' some bodysurfing and a morning or two of paddling his beloved surf ski. Sometimes, he played a game of golf or tennis and, when time permitted, he read biographies and the 'Classics' or played chess with his son Chris. 'It kept me sane', he recalled years later. 'I just had to keep grinding away every weekend. You can do it, but you can't do it forever. In retrospect, it was too much. It took a big toll and left me depleted. My body and I burned out. Sooner or later, everything breaks.'

Longing to retire from RNSH, he primed colleagues to replace him. Helen Johnston, Cousins's loyal and hardworking secretary for twenty years, recalled him mentoring colleagues for the role, though 'at the critical moment', each of them rejected the job offer.[14] 'Whenever I thought one of my colleagues would accept the role', he said, 'they ended up deciding against it. Instead, they went into private practice. It was a gruelling job, and 'no-one could face it.'

One reason he was eager to retire from RNSH was that, in June 2004, the Australian and New Zealand College of Anaesthetists (ANZCA) appointed him as its president. As he had done when he commenced his term as International Association for the Study of Pain (IASP) president, he articulated an ambitious agenda to members. In his first message to them in the *ANZCA Bulletin*, he declared that the anaesthesia profession faced serious challenges, including

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[11] Michael Cousins, 'Acute Pain Services in Australia', World Congress on Regional Anaesthesia & Pain Therapy, Barcelona, Spain, June 2002, MJC Private Collection.

[12] Michael Cousins, 'Pain Associated with Spinal Cord Injury: Mechanisms and Treatment', World Congress on Regional Anaesthesia & Pain Therapy, Barcelona, Spain, June 2002, MJC Private Collection.

[13] Russo, 'The Michael J. Cousins Lifetime Achievement Award'.

[14] Helen Johnston, interview by GKD, 12 September 2023.

maintaining professional standards and addressing shortages of anaesthetists in public hospitals, especially in rural areas. Rallying his troops, he urged his colleagues to serve on the eight committees he was establishing to resolve the crises threatening the profession, adding: 'As President of ANZCA I am committed to a plan for ANZCA to do more for all Fellows, however, to rephrase John F Kennedy: Ask not now what ANZCA can do for you … but what you can do for ANZCA.'[15]

Concurrently, Cousins continued crusading for access to pain management to be considered a human right. In 2000, the *Medical Journal of Australia* published his editorial 'Relief of Acute Pain: A Basic Human Right?', which concluded with the statement:

> There is a need for more focus on acute pain, changes in attitudes and practices, and adoption of a general view that relief of acute, severe pain is a basic human right, limited only by our ability to provide it safely in the circumstances of individual patients.[16]

A critical mass of allies, mostly within IASP, shared this view, and, on 11 October 2004, the World Health Organization (WHO), in partnership with IASP and IASP's European Chapter, sponsored a 'Global Day against Pain' in Geneva. Its theme was 'the Relief of Pain Should Be a Human Right'.[17] The proceedings were webcast live around the world, enabling thousands of people to participate in this historic event. However, not everyone in the pain world agreed with the contention, and resistance was brewing in some quarters.[18]

Four years later, in collaboration with Daniel Carr, an anaesthesiologist and pain medicine specialist, and the palliative care physician and lawyer Frank Brennan, Cousins published an editorial in the journal *Pain* entitled 'Pain Relief: A Universal Human Right'. The trio argued that 'failure to provide pain relief when this is available is a form of abandonment. In extreme cases, it would be regarded as "torture by admission".'[19]

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[15] MJC, 'President's Message', *ANZCA Bulletin* 13, no.2 (June 2004): 1–6.

[16] Michael Cousins, 'Relief of Acute Pain: A Basic Human Right?', *Medical Journal of Australia* 172, no. 1 (2000): 3-4.

[17] Arthur G. Lipman, 'Pain as a Human Right: The 2004 Global Day Against Pain', *Journal of Pain & Palliative Care Pharmacotherapy* 19, no. 3 (2005): 85–100.

[18] Sullivan and Ballantyne, *The Right to Pain Relief*, 78.

[19] Frank Brennan, Daniel Carr and Michael Cousins, 'Pain Management: A Fundamental Human Right', *Anesthesia and Analgesia* 105, no. 1 (2007): 205–21.

In 2004, Cousins also escalated his campaign for chronic pain to be viewed as a chronic disease. If this initiative succeeded, he thought, it would profoundly influence the way politicians, healthcare bureaucrats, medical professionals and hospitals prioritised funding for the treatment of chronic pain. In a review article that he and Philip Siddall published that year in *Anesthesia and Analgesia*, they argued that chronic pain was a disease in its own right rather than a passive warning signal of an underlying disease process or tissue damage. Outlining the evidence supporting this contested concept, they explained that for chronic pain to qualify as a disease entity, it should have its own pathology, symptoms and signs rather than merely being seen as a symptom of another disease process. Chronic pain met the criteria for a disease entity, they insisted.[20]

This position was controversial and polarised opinion among Australia's pain community.[21] Though Cousins faced intense criticism from some of his colleagues, he charged ahead, determined to convince them of the veracity of this contention. Five years later, he was heartened when the brain neuroimaging researchers Irene Tracey and Catherine Bushnell argued that the functional, structural and chemical changes in the brain associated with chronic pain 'put it into the realm of a disease state'.[22]

In 2019, Siddall admitted that viewing chronic pain as a disease entity was more than a physiological or clinical issue:

> It's also a political issue because the medical profession has always viewed chronic pain as a symptom of an underlying condition. The outcome of viewing pain as a disease is crucial because it means the health system treats it differently, and it attracts more recognition and resources.[23]

In Australia, the principal opponents to the notion were Milton Cohen, David Buchanan and John Quinter. Viewing pain as a disease was a circular argument, the trio argued, because it 'conceives of pain as a "thing" that is itself capable of producing an effect'. Such reasoning was problematic, they believed, because of the 'confusion of pain as a symptom, a cause and a pathology; and the fallacy that can arise when an interpretation is claimed to be a truth'. The

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[20] Philip Siddall and Michael Cousins, 'Persistent Pain as a Disease Entity: Implications for Clinical Management', *Anesthesia & Analgesia* 99 (2004): 510–20.

[21] Milton Cohen, interview by GKD, 1 October 2019.

[22] Irene Tracey and M. Catherine Bushnell, 'How Neuroimaging Studies Have Challenged Us to Rethink: Is Chronic Pain a Disease?' *Journal of Pain* 10, no. 11 (2009): 1113–20.

[23] Siddall, interview, 1 August 2020.

article they published in the journal *Pain Medicine* concluded with the statement: 'The proposition that chronic pain is a disease cannot be supported on clinical and pathological grounds.'[24]

In 2018, Sullivan and Ballantyne expressed a similar view in the *Journal of Pain*:

> Chronic pain cannot be understood simply as a symptom. Does that mean chronic pain is a disease? We do not think so. Although we accept that abnormalities on brain structural and functional neuroimaging are associated with chronic pain, it is not clear whether these are causes or effects of chronic pain.[25]

Ballantyne and Sullivan questioned whether designating chronic pain as a disease of the body or brain is helpful or harmful to patients. 'Can the disease designation help advance treatment, and is it needed to achieve future therapeutic breakthrough?' the pair asked. 'Or does it make patients over-reliant on medical intervention and reduce their engagement in the process of recovery?' The two authors concluded:

> Chronic pain is sometimes a symptom and may sometimes be its own disease. But here we question the value of a disease focus for much of chronic pain for which patient involvement is essential, and which may need a much broader societal approach than is suggested by the disease designation.[26]

Some colleagues suspected Cousins's campaign would fail because it was seen as such an overt political move. Whether it was political manoeuvring or genuinely driven by a fervent belief in its correctness was unclear. Whether it would succeed when so many highly regarded pain specialists opposed it was equally uncertain.

In Goucke's view, the debate over classifying chronic pain as a disease was a matter of semantics.[27] While viewing the concept as an excellent idea, he acknowledged that some people did not accept it. During his career, he assessed hundreds of patients living with chronic pain. These patients initially experienced acute pain following surgery or an injury; however, they 'ended up with chronic pain, and this pain is their problem rather than the initial injury', he

[24] Milton Cohen, John Quintner and David Buchanan, 'Is Chronic Pain a Disease?' *Pain Medicine* 14, no. 9 (2013): 1284–88.

[25] Jane Ballantyne and Mark Sullivan, 'Is Chronic Pain a Disease?' *Journal of Pain* 23, no. 10 (1 October 2022): 1651–65.

[26] Ballantyne and Sullivan, 'Is Chronic Pain a Disease?', 1651–65 (original emphasis).

[27] Goucke, interview.

argued. 'If you accept that pain can be freestanding, it lets you focus on managing the pain, rather than doing more and more tests and more and more operations.'[28]

Despite a lack of consensus, many health authorities and governments worldwide have enshrined the concept of chronic pain as a disease in their policies and laws.[29] IASP recently clarified the debate when it published ten papers in *Pain*, outlining an updated and more nuanced classification system for chronic pain.[30] In May 2019, WHO released a new edition of its *International Classification of Diseases (ICD-11)*[ii] that systematically represented chronic pain diagnoses.[31]

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In 2004, Brenda Lau was completing her anaesthesia training at the University of British Columbia, and, in her last year, she studied chronic pain. It intrigued her, so she searched for an accredited training program that would give her a fellowship in pain medicine. Lau came to Australia because 'Michael Cousins ran the best accredited training program in the world'. Lau 'loved every minute of the program'[32] and, after qualifying as a pain medicine specialist, she told Cousins she planned to remain in Australia for another year to study health economics.[iii]

At first, Lau's decision surprised Cousins because he had assumed she would be eager to return to Canada. Her passion for pain medicine matched his own and he offered to act as her supervisor while she completed a master's degree in medicine at the University of Sydney. The pair met every Friday afternoon for an extended chat about pain medicine and its future. Lau cherished these conversations and appreciated the time Cousins spent with her. 'Although he was extremely busy, he was a patient man who thoroughly enjoyed sharing his knowledge', she recalled. 'I think we had a unique relationship because I love pain medicine too.'[33]

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[28] Goucke, interview.

[29] James Strong, 'Nomination for Professor Michael J. Cousins, Council for the Order of Australia', 1, MJC Private Collection.

[30] R. D. Treede, W. Rief and A. Barke, 'Chronic Pain as a Symptom or a Disease: The IASP Classification of Chronic Pain for the International Classification of Diseases', *Pain* 160, no. 1 (January 2019): 19–27.

[31] Beatrice Korwisi et al., 'Chronic Pain in the 11th Revision of the International Classification of Diseases: Users' Questions Answered', *Pain* 163, no.9 (September 2022):1675–87.

[32] Lau, interview.

[33] Lau, interview.

Sometimes on weekends, Cousins and Michele invited the pain medicine fellows, including Lau, to join them at Palm Beach. 'Despite Michael and Michele having achieved so much for so many, on a personal level, they were grounded, laid-back, incredibly warm and welcoming to their colleagues and fellows', Lau remembered. 'Michael's favourite pastime was surf skiing, and to him, every moment was a "teaching moment". He believed we can learn just as much about pain medicine on the water as we can in a hospital ward—patience, agility, problem-solving, pattern recognition and intuition.'[34]

One project that kept Cousins and Goucke busy was compiling the mountain of documents required by the Australian Medical Council (AMC). It took them several years; however, to their great relief, in 2005, AMC designated pain medicine as a specialty. Australia was the first country in the world to achieve this recognition.[35]

According to Milton Cohen, gaining specialty recognition was a crucial step forward because, until then, pain and its treatment had always held such a low priority. 'Pain was only ever a symptom of something else, not a problem in its own right.'[36] Goucke shared this view. Once Australia secured recognition of pain medicine as a specialty, Europe followed, and so did Ireland. 'It was just waiting for someone to crystallise the thinking', Goucke asserted.[37] It meant pain medicine physicians could charge patients specialist rates, encouraging more doctors to become pain specialists and many more patients to access pain management services.[iv]

Another memorable event in Cousins's life occurred in 2005—his beloved daughter Jane married her American fiancé Charlie Kuehn in the chapel at her father's high school. As Cousins walked down the aisle with his only daughter, his eyes filled with tears.[38] It was a bittersweet moment for him because he knew the following morning Jane would leave to live in America.

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[34] Lau, interview.

[35] Charles Brooker, 'A Festschrift Presentation in Honour of Michael J. Cousins AO', 19 May 2016, MJC Private Collection.

[36] Cohen, interview.

[37] Goucke, interview.

[38] Jane Cousins, interview, 7 January 2021.

Back at PMRI, Blyth's doctoral research had included an analysis of the societal and personal costs of chronic pain, including the effects of pain on work performance, levels of disability, and use of pain-relieving drugs and health services.[39] In the first study in Australia, and one of very few worldwide, Blyth documented total lost workdays and associated annual costs due to the condition. Her study was the first to show lower levels of disability in people using active self-management strategies, such as paced exercise and cognitive behavioural therapy.[40]

In 2007, Blyth chaired the steering committee for an Access Economics study, *The High Price of Pain*.[41] Access Economics estimated that chronic pain cost the Australian economy $34 billion per annum, making it the nation's third most costly health problem. As the study leader, Cousins acted as the media spokesperson:

> It's now possible to manage persistent pain in seventy to eighty percent of patients, yet fewer than ten percent of individuals obtain pain relief. Federal and state governments could save enormous amounts of public funds by providing the resources to deliver proper treatment. At least half of the patients who access effective treatment get back to a reasonable lifestyle, offering savings on hospital and doctor visits, x-rays, surgery, medications and productivity.[42]

Shortly afterwards, Cousins learned that RNSH planned to build a new campus. Ecstatic, his first thought was that the project would enable him to expand the pain clinic to meet the escalating demand for pain management services. However, to his dismay, he soon learned that the hospital's plans did not include a pain centre. Aghast, he could not believe the administrators had excluded a pain clinic when the demand for pain services was so strong. It felt like deja vu. At sixty-eight, he had not expected to relive his Flinders Medical Centre (FMC) ordeal. Reeve suggested that several forces were at play—cost-cutting, historic turf wars, tall poppy syndrome and professional jealousy.[43] Cousins knew fighting for the pain centre would be an 'uphill battle' and a 'monumental test'; however, he resolved to 'get the best deal for people living with pain'.

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[39] Fiona Blyth, L. March and Michael Cousins, 'Chronic Pain-Related Disability and Use of Analgesia and Health Services in a Sydney Community', *Medical Journal of Australia* 179, no. 2 (2003): 84–87.

[40] Fiona Blyth et al., 'Self-Management of Chronic Pain: A Population-Based Study', *Pain* 11, no. 3 (2005): 285–92.

[41] Access Economics, *The High Price of Pain. The Economic Impact of Persistent Pain in Australia*, November 2007, https://www.painaustralia.org.au/static/uploads/files/mbf-economic-impact-wffhrlzqsaht.pdf.

[42] Tamara McLean, 'Pain Comes with $34 Billion Price Tag', *AAP*, 19 November 2007.

[43] Reeve, interview.

Cousins demanded an urgent meeting with the hospital's administrators, and, when it was granted, took Charles Brooker, head of RNSH's pain management department, with him. On the way, he asked Brooker to tread on his toes under the table if he became too fired up during the meeting. When they reached the designated room, they sat on one side of a large boardroom table. Three hospital managers dressed in dark suits sat on the other side. Cousins felt as if he could 'cut the air with a knife' because the atmosphere was so tense. Brooker, too, sensed the hostility.[44]

The meeting started with a senior manager explaining that the hospital used a 'patient-centred care model' to determine funding priorities. Cousins and Brooker glanced at each other, knowing the model would leave their pain patients with nothing.[45] Cousins stood up, pushing back his chair noisily:

> Thanks for outlining all this. The model we established for multidisciplinary care is well accepted around the world and we raised considerable community and government support to build the current centre. I'm sure you'll agree we're setting a high standard of care for patients with this model. So, we just need to know where the centre is going to be located.

Returning to his seat, he continued pushing the point, dominating the meeting so it could not move on. Afterwards, as they sprinted back to the pain clinic—Cousins with sore toes—Brooker asked him for some tips on negotiating. The response astounded the young pain medicine specialist:

> Discuss nothing specific at a meeting. Try to come out of it without agreeing to anything, then negotiate in the background later. Arrive ready to confirm an agreement you've already negotiated because it's impossible to get a controversial topic sorted out in your favour in a meeting. Ensure you nail down everything before a meeting. If you haven't settled an agreement beforehand, it's best to go in, grit your teeth and get out conceding nothing.[46]

On the home front, Cousins continued to treasure his weekends at the beach. His family's holiday house provided an escape from his constant battles about the hospital's redevelopment plans. It also acted as a natural meeting place for his adult children, grandchildren, friends and siblings. James Cousins had moved to Brisbane, though he and his family always stayed with

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[44] Brooker, interview.

[45] Brooker, interview.

[46] Brooker, interview.

his parents for the Christmas holidays, and Jane and Charlie often flew across from America to join them. Cousins loved it. 'Having his family around him was the most important thing for Dad', Jane reminisced. 'He was at his happiest when we sat around the house talking or strolling down to the beach. For him, just being with us is what brought him joy.'[47]

Throughout the following months, Cousins and Brooker attended several fractious meetings about RNSH's redevelopment plans. Brooker admired the way his mentor operated during this exasperating process:

> Whenever Michael couldn't achieve an acceptable outcome, he went over people's heads and rang someone more senior. He wasn't afraid to go around people, to a point the person he was talking to might be a little surprised he had gone above them, but they would admire his audacity. Once in front of a senior person, Michael would offer them an eminently reasonable arrangement. 'I think we can achieve this', he would say. 'It'll be a little bit of cost here, but we can make it back, and the benefits will be X, Y and Z.'[48]

Brooker noticed that Cousins always crafted a game plan to overcome roadblocks. 'Despite his intense frustration, Michael never lost his cool and he was always polite but doggedly persisted', Brooker remarked. When something did not go Cousins's way, he kept driving forward and brushed off disappointments. Struggling through some challenging times, he just 'gritted his teeth and marched on' until he had accomplished whatever he was trying to achieve. 'He wasn't affected by other people's opinions of him, which probably helped him survive many turbulent months of hostile meetings', Brooker added.[49]

Reeve agreed with Brooker's summation of Cousins's approach to negotiation and modus operandi:

> Even though Michael's ideas or requests might get up somebody's nose, he didn't care. And that's probably his strength, that he wasn't easily deterred. Look at how he was with John Bonica, a tough man, but Michael strode over that. Bonica didn't intimidate him. There's power and authority. You never worry about power, but you need authority to progress. It isn't your privilege to command, it's your privilege to persuade others to follow your ideas. And Michael fitted that.[50]

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[47] Jane Cousins, interview, 7 January 2021.

[48] Brooker, interview.

[49] Brooker, interview.

[50] Reeve, interview.

In late 2008, the board of the Pain Management Research Institute (PMRI) recruited a former pharmacist and public relations consultant, Lesley Brydon. Board members were eager for Brydon to increase awareness of PMRI's research on the value of interdisciplinary pain management and to help raise funds for the centre's ambitious research program.

Brydon created a briefing pack for journalists about PMRI and its research programs, issued a media release, then organised a round of television, print and radio interviews for Cousins. The response astonished her. In the days following the publicity, the pain clinic's phone 'rang off the hook' as people desperate for help telephoned. The response prompted Brydon to wonder what was happening in pain clinics around the country, so she contacted the registered pain clinics in each state. 'There were fifteen pain clinics, all in major cities, but no two of them offered the same programs', she recalled.[v] And the 'waiting lists were diabolical'.[51]

The lack of best practice interdisciplinary pain management services throughout Australia troubled Cousins. For several days, he and Brydon discussed the findings of her survey, considering ways to improve access to pain services. A national pain strategy was urgently needed, they concluded. It would serve as a blueprint for best practice management of acute, chronic and cancer pain for all Australians. A necessary first step would be a consultation process within Australia's pain community, the pair agreed, to enable them to understand what was 'happening on the ground', particularly in regional and remote areas. Then they would assemble interdisciplinary working groups to draft a national strategy that would be presented to stakeholders for endorsement at a national pain summit.

Their ambitious goal was to convince health ministers around Australia of the importance of funding best practice management of acute, chronic and cancer pain as a healthcare priority. Cousins asked Brydon whether she would help manage the consultation and strategy development process and organise the summit, which they agreed would be held at Parliament House in Canberra. 'Yes, absolutely', she said, though she had no inkling of what she was taking on. Agreeing that the thrust of the strategy would be to set up a standardised interdisciplinary approach across the nation, they set to work in mid-2009.

Cousins created a list of summit support staff, roles, responsibilities and cost estimates,[vi] and Brydon developed a resources brief.[52] Then he approached ANZCA, APS and FPM, inviting

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[51] Lesley Brydon, interview by GKD, 12 April 2019.

[52] L. Brydon, 'National Pain Summit Resources Brief', 3 June 2009, MJC Private Collection.

them 'to collaboratively lead the process'. The three organisations willingly accepted his proposal, agreeing to provide seed funding towards administrative costs. He also phoned several leading pain medicine professionals, inviting them to form a multidisciplinary steering committee. Recognising the imperative to involve patients in the process to understand and meet their needs, Brydon approached the Consumers Health Forum and Chronic Pain Australia for consumer representation.[53]

At its first meeting, the steering committee formed three working groups and four reference groups to provide input on acute pain, cancer pain and palliative care; paediatric pain; and pain in older persons.[vii] Fran Boyle was a member of the cancer pain working group, and I was a member of the primary care working group as a consumer advocate.[54] Contemporaneously, Cousins embarked on a fact-finding tour to learn how other countries managed chronic pain.[viii]

During his travels, Cousins continued negotiating with RNSH's administrators about its redevelopment plans. When he returned, and after many months of sleepless nights, the hospital offered the pain centre space in a small section of its main building. Wisely, Brooker knew it would be inadequate for their needs and risked 'being whittled away' for other uses such as extra operating theatres and offices. Though Cousins was keen to accept the allocation because he feared they might end up with nothing, Brooker persuaded him to reject it.[55] It was a risky move.

Several more months of fierce negotiations followed, Cousins admitting he 'got fired up at times'. He alleviated the pressure of this monumentally stressful time in his life by reminding himself of Bonica's mantra: 'Get the facts right, son, and never never give up. Get the facts right then persevere, persevere, persevere.' This is exactly what Cousins did. Dogged, he kept fighting, yet, at times, he lost all hope of saving the pain clinic. 'It took a lot of quiet determination', he recalled. 'It wouldn't have worked if I'd been outright aggressive, but I knew I had to hold my ground.'

Eventually, the hospital's administrators offered the pain centre 1,500 square metres in the Douglas Building, located across the carpark from the main hospital building. The generous

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[53] Brydon, interview, 8 April 2019; MJC, 'Speech Notes', National Pain Summit, Canberra, 11 March 2010, MJC Private Collection.

[54] National Pain Summit Initiative, *National Pain Strategy*, viii, MJC Private Collection.

[55] Brooker, interview

space would allow the construction of a state-of-the-art pain centre that better met the skyrocketing demand for pain management services. 'We only won in the twilight hours of the process', he admitted. When the new pain centre opened, pain research, education and the pain clinic occupied adjacent spaces, enabling patients to access an interdisciplinary team in a 'one-stop-shop'.

During their decades of working with Cousins, Siddall and Kathleen Foley marvelled at how he handled challenging situations. Foley, a longtime IASP Council colleague, said Cousins never pulled back when confronted by formidable opponents. His approach was: 'Well, what are our next steps? And the steps after that? How do we move this forward?'[56] Siddall affirmed this view. He noticed that Cousins was not someone to 'lick his wounds and feel sorry for himself or give up'. Instead, he pushed on a bit harder and devised another way around the roadblock. 'Backtracking a couple of steps, he did one of two things—either navigated around the obstacle, which was his preferred option, or retreated a couple of steps then tried again with a few more reserves on board.'[57]

Foley admired the way Cousins was 'always in the trenches' doing research, treating patients and lobbying for improvements in pain management. 'He showed by his achievements how a person could be a high-level clinical scientist, a compassionate, skilled clinician and an advocate', she said.[58]

Meanwhile, Cousins and Brydon continued developing the *National Pain Strategy*. They knew implementing a national approach required federal government endorsement and financial support. Cousins had spent decades lobbying politicians about the societal and personal costs of pain, sharing research that revealed the benefits of interdisciplinary pain management: reduced suffering, disability payments, healthcare and pharmaceutical costs; and increased numbers of people returning to work after an injury.[59] The pair hoped the economic lever of reducing disability payments and other healthcare costs through a national plan would convince

[56] Kathleen Foley, interview by GKD, 26 September 2019.

[57] Philip Siddall, interview by GKD, 1 August 2019.

[58] Foley, interview.

[59] Blyth et al., 'Self-Management of Chronic Pain', 285–92.

the federal government to embrace the strategy. However, they could not secure a meeting with the federal health minister, Nicola Roxon.[60]

Despite the lack of federal government support, the consultation process proceeded smoothly. On 19 October 2009, four months after starting the project, the steering committee released a draft *National Pain Strategy* for public comment. Brydon issued a media release, sparking an avalanche of interview requests. In media interviews, Cousins insisted that the medical profession seriously mismanaged chronic pain:

> Currently in Australia and worldwide, it's fair to say pain management is shockingly inadequate. This results from inadequacies in knowledge, training, attitudes, practices, resources and structures. Pain is one of Australia's biggest health issues today, every bit as big as cancer, AIDS and coronary heart disease. Australia urgently requires a public education campaign to promote understanding of chronic pain. People living with it are stigmatised as bludgers and copping out on their workmates. Today marks the beginning of an historic opportunity to address what we could describe as the largest undiscovered gap in healthcare, not just in this country but worldwide.[61]

In an ABC radio interview the same day, Cousins reiterated his message about the stigma associated with chronic pain. 'There are lots of myths about chronic pain—"You know, it's all in your head. You're just trying to get strong painkillers. You're just trying to get off work"—and myths, of course, are very, very difficult to dispel.'[62]

During the following weeks, the steering committee received forty-eight submissions from consumer and professional bodies, industry and individuals. Steering committee members reviewed 'every line of feedback', incorporating it into the draft strategy. They planned to debate it at the National Pain Summit a few weeks later. In the Foreword to the *National Pain Strategy*, Cousins expressed his admiration for everyone involved in its creation:

> In more than forty-six years in healthcare, I have known no other health initiative to harness such a breadth and depth of experience on a single health problem. The most

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[60] Lesley Brydon, interview by GKD, 8 April 2019

[61] Jon Pierik, 'Management of Chronic Pain "Inadequate"', *AAP Bulletins*, 19 October 2009.

[62] MJC, 'Calls for a New Way of Dealing with Pain', interview by Eleanor Hall, *World Today*, Australian Broadcasting Corporation, 19 October 2009, https://www.abc.net.au/radio/programs/worldtoday/calls-for-a-new-way-of-dealing-with-pain/1108962.

> remarkable outcome has been the high level of agreement about what needs to happen in specific and practical terms.[63]

A few months later, on Thursday 11 March 2010, the mood was electrifying in the Great Hall of Parliament House in Canberra as 200 delegates, including representatives from the field of pain management and anaesthesia, consumer groups, mental health, rural health, palliative care, paediatrics and general practice, to name a few, gathered to discuss the updated draft of the *National Pain Strategy*. I was one of the patients who attended as a consumer advocate.

Nicola Roxon opened the event, which Norman Swan, producer and presenter of Radio National's *The Health Report*, facilitated. Cousins chaired the proceedings.[64] Feeling excited and optimistic, yet on edge, he sensed the summit was a pivotal moment in the history of pain medicine in Australia. It also represented the culmination of his four-decades long quest to reduce suffering by improving the treatment of pain.

In his opening address, Cousins said that it was a historic day in Australian health because the summit participants would debate the world's first national pain strategy, aiming to reach a unified position. Declaring that everyone in the room shared a responsibility to those who experienced chronic pain, 'who are stigmatised, disbelieved, demoralised and grossly undertreated', he demanded that federal and state governments back a community-led program to destigmatise chronic pain. Recounting how people with chronic pain faced discrimination, he contrasted their management to people with other chronic diseases. 'Addressing this situation is a moral imperative', he exhorted.[65]

The esteemed health economist Helen Owens, who prematurely left her role as a Productivity Commission commissioner because of poorly managed chronic pain, shared her story of struggling to access pain management services.[66] So did Symantha Liu's former husband, Olympic swimming champion Kieren Perkins, who represented carers.[ix] International pain experts also spoke of their experiences in pain centres and policymaking circles overseas.

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[63] National Pain Summit Initiative, *National Pain Strategy*, v.

[64] MJC, 'Program National Pain Summit', 11 March 2011, MJC Private Collection.

[65] MJC, 'Speech Notes', National Pain Summit, 2010, MJC Private Collection.

[66] Helen Owens, 'Pain Management: A Cancer Patient's Perspective', National Pain Summit, Parliament House Canberra, 11 March 2010, MJC Private Collection.

Following a day of intense discussion and debate, the strategy was unanimously supported[67] and Cousins called on the federal government to appoint a taskforce to implement it.

The world's first *National Pain Strategy* provided a blueprint for the treatment of pain, recommending an interdisciplinary approach to deliver best practice pain management. The Great Hall of Parliament House erupted as delegates celebrated. Many of them had volunteered to join the multiplicity of committees that developed the strategy, and they knew that if the federal government implemented it across the nation, it would improve access to specialist pain management services. Later, the United States, Canada, England and several European countries modelled their national pain strategies on that of Australia.[68]

During the summit's lunch break, the broadcaster Eleanor Hall interviewed Cousins on the national current affairs program *The World Today*.[69] Brydon had also organised several other media interviews for him, resulting in over thirty-five newspaper articles, radio broadcasts and television appearances. Cousins told journalists that the summit's delegates were calling for governments and the medical profession to recognise chronic pain as a disease: 'The moment chronic pain is recognised as a chronic disease and treated within the chronic disease category, patients will have more access to pain management services.'

Newspapers across the nation reported his assertion that fewer than ten percent of those suffering from chronic pain can access effective treatment. 'Very simply, it's undertreated because it's not on the radar. I think this is a discrimination issue against patients with the disease of chronic pain compared to other chronic diseases.'[70]

On the evening of the summit, Cousins appeared on the Australian Broadcasting Corporation's flagship current affairs program *The 7.30 Report.* Despite an exhausting day at the summit, he looked invigorated and much younger than his seventy-two years; his stamina was astonishing. 'Painful Reality—Patients Let Down' was broadcast to a national prime-time audience. In a

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[67] Boyle, interview; Goucke, interview; Cohen, interview; Brydon, interview

[68] Goucke, interview; Brydon, interview 12 April 2019; Boyle, interview. Also, see National Institutes of Health, *National Pain Strategy Report. A Comprehensive Population Health-Level Strategy for Pain* (Washington: National Institutes of Health, 2011), accessed 4 April 2020, https://www.iprcc.nih.gov/sites/default/files/documents/NationalPainStrategy_508C.pdf.

[69] MJC, 'Chronic Pain Summit Opens', interview by Eleanor Hall, *World Today,* Australian Broadcasting Corporation, 11 March 2010, https://www.abc.net.au/worldtoday/content/2010/s2843006.htm.

[70] Natasha, Rudra, 'System 'Failing' Chronic Pain Sufferers', *Canberra Times*, 12 March 2010.

carefully modulated voice, Cousins proclaimed that doctors and health professionals in Australia neglected people who suffered from chronic pain.[71]

'Chronic pain isn't given the priority it deserves', he told Kerry O'Brien, a highly acclaimed veteran political journalist:

> The management of pain is shockingly inadequate. Myths abound in the general community, and I'm afraid to say this, across the medical and healthcare profession also, and a lot of people with chronic pain are subjected to not being believed, to implications they're trying to seek opioids. And basically, they finish up receiving very unsatisfactory pain relief.[x]

The *National Pain Strategy* offered Cousins a national platform, and he embraced it with vigour to articulate a message he had relentlessly communicated for decades. Goucke participated in the summit, and its results impressed him; he assumed Cousins had prearranged the outcome: 'Michael knew precisely what he wanted to come out of it.' Goucke admired how Cousins 'lobbied, facilitated and organised, getting everyone together and ensuring they had their say. While his ideas were not universally accepted, most of them were.'[72]

Boyle, who also attended the summit, agreed. She said Cousins understood that advancing pain medicine in Australia was about much more than running a pain clinic. Frustrated with the medical profession's traditionally siloed approach to healthcare, he recognised that the silos had to be eclipsed to make way for a national framework that was capable of sustainably improving access to pain management services. 'The Faculty of Pain Medicine achieved this goal to some extent', she stated, 'however, attitudes and funding models still required radical change'.

Boyle acknowledged that, while it took a 'bulldozer' to achieve a national strategy, she did not perceive Cousins's approach as offensive. 'I saw it as leadership', she remarked, adding:

> It required someone to herd the key players into a room and give them an incentive to cooperate, to believe something good would result from the process. Michael understood the need to create clinical guidelines to convince funding bodies that multidisciplinary pain management was evidence-based and good enough to pay for.

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[71] MJC, 'Painful Reality—Patients Let Down', interview by Kerry O'Brien, *The 7.30 Report*, Australian Broadcasting Corporation ,11 March 2010, https://www.youtube.com/watch?v=guiYQEJzIgw.

[72] Goucke, interview.

> His formula for success was: a) write the guidelines; b) get the silos together; c) get consumers involved; d) get the politicians on side; and e) get some money.[73]

Paul Wrigley, a senior RNSH pain medicine specialist, attended the summit and felt invigorated by it; he was confident that it represented a step forward in improving pain management across Australia. In the lead-up to the summit, Wrigley had contacted an advocacy body within the New South Wales Department of Health—the Greater Metropolitan Clinical Taskforce—urging it to embrace pain as a priority area of focus. A few weeks later, he and Cousins met with Hunter Watt, the taskforce's head, proposing that the state government develop a pain network to advise the health minister. Much to their surprise and delight, Watt agreed. From that point onwards, Wrigley and the pain medicine specialist Chris Hayes established the New South Wales Pain Management Network, 'setting the wheels in motion for major reform'.[74]

Summit delegates recommended the creation of a national advocacy body to help implement the *National Pain Strategy*. APS, ANZCA, FPM and PMRI heeded the call, leading to the formation of Painaustralia.[75]

Shortly after the summit, IASP invited Cousins to coordinate and chair its first International Pain Summit. Enthusiastically accepting, he sensed 'the time was right' to champion the concept of pain management as a human right. Immediately setting to work, he assembled a steering committee to plan the agenda.[xi]

After canvassing his ideas with the steering committee, its members agreed to pursue it. What followed was a lengthy process—via telephone and email—that involved representatives from sixty-four countries drafting, reviewing, editing and rewriting the Declaration of Montreal. Its simple message was: 'Access to pain management is a fundamental human right.'[76] To Cousins's disappointment, it 'hit a few roadblocks along the way' because several detractors argued that freedom from pain was not equal to access to clean water, education or freedom

[73] Boyle, interview.

[74] Paul Wrigley, interview by GKD, 20 August 2019; Chris Hayes, interview by GKD, 19 September 2019.

[75] Painaustralia, *Painaustralia Annual Report* (Canberra, 2011), 4–6, https://www.painaustralia.org.au/static/uploads/files/2011-annual-report-wfznhrrlawqb.pdf.

[76] IASP, 'Declaration of Montréal', 3 September 2010, https://www.iasp-pain.org/DeclarationofMontreal.

from slavery.[77] Others feared it risked being grossly misinterpreted to imply that everyone had the right to access opioids.

These criticisms perplexed Cousins. 'By the time I got it to the IASP Council meeting, I sensed I'd have a tough fight getting it accepted', he later admitted. To his immense relief, however, after a long and, at times, hostile meeting in Montreal, the IASP Council approved the draft as a working document for the International Pain Summit.

In early September 2010, after the 13th World Congress on Pain in Montreal, IASP hosted its International Pain Summit.[78] Over 260 IASP members from sixty-four countries, and representatives from professional and human rights organisations, assembled to debate the draft Declaration of Montreal. Michele recalls her husband was anxious because he thought it would be 'an uphill battle' to gain support for the declaration. 'We thought it was just pushing too hard', she stated. 'It was definitely out there.'[79]

Despite his qualms, Cousins confidently delivered the opening remarks: 'Today we hope to address the tragedy of unrelieved pain.'[80] Yet he worried that the delegates would not agree to accept the declaration because they believed it was too far-reaching.

The psychiatrist and pain medicine specialist Rollin Gallagher served on the summit steering committee, and he and Philipp Lippe also served as the American delegates and speakers at the summit. Gallagher recalled that the schedule was tight, with all sixty-four country representatives delivering a five-minute speech. 'The mood in the room was electrifying. Each delegate gave a short, impassioned presentation and we were running out of time because each participant gave such a powerful speech.' The consistency of participants' messages astonished Gallagher, irrespective of whether they were from well-resourced countries such as Australia and America or developing nations. 'Everyone in the room was committed to the same thing—how to get good pain management into all countries. It was inspiring to be a part of it, and everybody shared the same feeling.'[81]

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[77] Paul Glare, interview by GKD, 17 April 2019.

[78] IASP, 'International Pain Summit', 3 September 2010, https://www.iasp-pain.org/advocacy/international-pain-summit/.

[79] Michele Cousins, interview by GKD, 23 August 2019.

[80] MJC, 'Speech Notes', International Pain Summit, Montreal, September 2010, MJC Private Collection.

[81] Gallagher, interview.

At the end of an intense day, a sense of euphoria filled the room when participants unanimously voted to accept the declaration. They had agreed to the right of all people to have access to pain management without discrimination; the right of people in pain to have acknowledgment of their pain, and to be informed about how it could be assessed and managed; and the right of all people with pain to have access to appropriate assessment and treatment by adequately trained healthcare professionals.[82]

A few opponents report that peer pressure prompted them to vote in favour of the declaration: they question whether freedom from pain is the same as freedom from war, oppression or hunger, or immunising all children against crippling or deadly diseases, and ask whether pain is more or less important than these other issues.

In their book, *The Right to Pain Relief: And Other Deep Roots of the Opioid Epidemic*, Sullivan and Ballantyne argued that the right to pain relief advocated by the palliative care movement, which included Cousins, Bonica and IASP—'who have always seen themselves as on a moral mission to relieve suffering'[83]—provided unscrupulous companies such as Purdue Pharma with an unprecedented opportunity to exploit these humanitarian ideals through aggressive, illegal and immoral marketing.

Purdue's chair and president, Richard Sackler, was determined to capture the 'chronic pain market' after hearing claims, including by Bonica,[84] that one in three Americans lived with chronic pain. Highly incentivised Purdue sales representatives targeted doctors, aiming to convince them that the strong opioid OxyContin was not addictive or a candidate for abuse; until then, doctors had been reluctant to prescribe the opioid morphine because of its addictive potential. Complicating the picture, pain experts such as Melzack[85] and Kathleen Foley[86] suggested that morphine was not addictive in the presence of genuine physical pain.

In their meetings with doctors, Purdue sales representatives insisted that OxyContin was ideal for treating people living with chronic pain. Once doctors prescribed the drug, these Purdue

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[82] IASP, 'Declaration of Montréal'.

[83] Sullivan and Ballantyne, *The Right to Pain Relief*, 65–66.

[84] Keefe, *Empire of Pain*, 176.

[85] R. Melzack, 'The Tragedy of Needless Pain', *Scientific American* 262, no. 2 (1990): 27–33.

[86] Russell Portenoy and Kathleen M. Foley, 'Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases', *Pain* 25, no. 2 (1986): 171–86.

sales staff regularly visited them, pressuring them to 'titrate up' or gradually increase the dose from a low starting point to the maximum recommended dose because of the escalating revenues and commissions resulting from higher doses.[87]

Tragically, these corrupt marketing practices resulted in unprecedented prescribing of OxyContin, which contributed to the opioid epidemic. Millions of individuals became addicted to OxyContin, and hundreds of thousands of people have died from an opioid overdose. Many more remain addicted, and some turned to illicit heroin and fentanyl once stringent opioid prescribing laws were introduced.[88] Sullivan and Ballantyne claim: 'Purdue would never have succeeded in making billions from OxyContin if not for the work of John Bonica', the palliative care movement, Kathleen Foley and IASP.[89] Clearly, none of these people, who were driven by humanitarian ideals, would have suspected such an outcome.

One of the unexpected consequences of the Declaration of Montreal was that some people misinterpreted it to mean that everyone deserved to be pain-free. Rolf-Detlef Treede, a neuroscientist at the University of Heidelberg in Germany, said in retrospect that many critics consider this may have been one of the factors that precipitated the opioid crisis in the United States: 'This was not by design, but by misunderstanding', he stated. 'Our desire was to call attention to the need for a multimodal approach to the treatment of pain, not to say more access to opioids would solve the problem.'[90]

Sullivan and Ballantyne noted that an aspect of this misunderstanding was the various ways the term 'access to pain management' was interpreted. They suggested that to pain specialists it meant access to multidisciplinary pain care; however, general practitioners know 'few pain management techniques beyond opioids'.[91]

Roger Goucke challenged the assertion that the Declaration of Montreal contributed to the overprescribing of opioids. Insisting that the statement meant 'we need to try our best to help

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[87] Keefe, *Empire of Pain*, 217.

[88] Keefe, *Empire of Pain*, 353.

[89] Sullivan and Ballantyne, *The Right to Pain Relief*, 53.

[90] Kayt Sukel, 'A 10-Year Anniversary: Reflecting on the Declaration of Montreal, IASP', *Pain Research Forum*, no. 1 (August 2020), https://www.painresearchforum.org/news/143774-10-year-anniversary-reflecting-declaration-montreal.

[91] Sullivan and Ballantyne, *The Right to Pain Relief*, 79.

people minimise their pain', he added: 'You can't blame the opioid crisis on increasing interest in the effective and proper management of pain.'[92]

[92] Goucke, interview.

Chapter Eleven: Pain Procures a Seat at the Top Table

On 26 March 2011, the New South Wales Liberal Party won the state election and Jillian Skinner became the state's health minister.[1] The previous year, when Skinner was the shadow health minister, she had invited a downhearted Cousins to her Parliament House office. One issue they discussed was Cousins's distress about RNSH's redevelopment plans and the furious competition for space. Skinner counselled him to 'hang in there', promising that if the Liberal Party won the approaching state election, she would give pain management the profile she believed it deserved. Skinner had met Cousins many years earlier and had visited the pain centre several times, so she was aware of the ADAPT program. This was partly what motivated her to commit to a policy of developing a pain management plan as part of the Liberal Party's election platform.[2]

Around the same time, Painaustralia held its first board meeting in the Sydney offices of the law firm Corrs Chambers Westgarth. The board, chaired by the late James Strong AO, appointed Brydon as inaugural CEO.[i]

Milton Cohen, the Faculty of Pain Medicine's (FPM's) representative on the inaugural board, recalled the mood of the first few meetings. 'Painaustralia was like a fledgling emerging from an egg and learning to fly. But a tiny egg and a tiny fledgling.'[3] He admitted that it was challenging to establish a not-for-profit organisation in the public health sphere when the competition for funding included high-profile charities such as Beyond Blue and the National Heart Foundation, adding: 'Painaustralia's board members were trying to find their feet. They had two simultaneous tasks: to quickly gain a public profile and ultimately policymakers' and governments' attention. And they had to build a supporter base to attract donations and establish momentum.'[4]

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[1] NSW Electoral Commission, *Report on the Conduct of the NSW State Election 2011* (Sydney: NSW Government, 2011), https://www.elections.nsw.gov.au/NSWEC/media/NSWEC/Reports/Election%20reports/2011-State-election-report-(PDF-7.8MB).pdf.

[2] Jillian Skinner, interview by GKD, 24 April 2019.

[3] Cohen, interview.

[4] Cohen, interview.

Around this time, IASP invited Cousins to draw up a set of guidelines for developing national pain strategies. He assembled a working party of IASP representatives from fifteen developed and developing nations. The working party asked IASP members to submit examples of national pain programs, and it surveyed IASP country presidents, asking them to identify barriers to effective pain management in their nations. After analysing submissions from nineteen member countries and feedback from IASP chapters, the working party created *Desirable Characteristics of National Pain Strategies.*[5]

During this period, Skinner forged ahead with her plans. She changed the Greater Metropolitan Clinical Taskforce's name to the Agency for Clinical Innovation and instructed it to set up the New South Wales Pain Management Taskforce. After appointing Richard Chye, head of palliative care at Sydney's St Vincent's Hospital, as chair, she asked Cousins to join as an adviser. Skinner charged the taskforce with advising her on what she needed to do to implement a statewide pain management service.[6]

In May 2011, Skinner told journalists that she had set up a taskforce to address issues raised at the National Pain Summit.

> It's vital for NSW to take the lead on delivering better pain management services. Severe and chronic pain has an enormous impact on sufferers, and on society as a whole. The costs, financial, emotional and mental, take their toll on everyone, which is why we must be better equipped to meet demand and try to reduce waiting times.[7]

After decades of trying to influence politicians, Cousins was heartened to hear Skinner's words, though he longed for her sentiments to be more widespread among the nation's politicians and healthcare bureaucrats.

At the Agency for Clinical Innovation, Jenni Johnson was the network manager for pain, and she played a lead role in the taskforce. Johnson travelled to every pain clinic in New South Wales and interviewed staff about their challenges and resourcing needs. She recalled that the taskforce used the *National Pain Strategy* like a skeleton. 'Applying its principles to the NSW

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[5] IASP, *Desirable Characteristics of National Pain Strategies* (Boston: IASP, November 2011), https://www.iasp-pain.org/wp-content/uploads/2022/08/DesirableCharacteristics_Nov2011.pdf.

[6] Skinner, interview.

[7] 'State Government to Set up Pain Taskforce', *St George & Sutherland Shire Leader,* 10 May 2011.

plan, we devised several recommendations that formed the plan's core', Johnson explained. 'We wanted to ensure NSW implemented interdisciplinary pain management across the state.'

Johnson admired the way Cousins 'worked behind-the-scenes' with Skinner managing the 'politics of the process'. He never let the system daunt him, she noticed, no matter how much resistance he faced. 'Michael Cousins just kept banging on the door with the message that pain management was a human right, and everyone had a right to access evidence-based treatment', Johnson said. 'It was a powerful message. He took it to every meeting and started every discussion with it. Michael put pain management on the agenda in NSW and kept it there for many years, so it eventually became a government priority.'[8]

Deeply committed to educating medical and allied head professionals about pain and its management, Cousins founded a new academic discipline of pain management, the first in the world, at the University of Sydney in 2011.[9] Simultaneously, he continued to pursue his political agenda at a national level. It was critical to gain acceptance of chronic pain as a chronic disease in its own right, he believed, as distinct from a symptom of disease. His goal was to use terminology that rightfully positioned pain in the minds of medical professionals, governments and the public to ensure that it gained the prominence it required to attract sufficient funding to improve its management.

However, when he and Brydon discussed the matter with senior health department officials, they 'hit a brick wall'. It did not help that opinion among pain specialists was divided or that consumer advocates believed defining chronic pain as a disease might increase the stigmatisation of patients. Brydon told Cousins that they had no hope of convincing the federal government of the veracity of the concept and that continuing to pursue it with them might alienate key health bureaucrats. 'It's one of the few times in my decade of working with Michael he looked dejected and as if he might give up', Brydon recalled.[10]

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[8] Jenni Johnson, interview by GKD, 19 April 2019.

[9] Shipton, 'Honouring a Giant'; Geoffrey Kaye Museum of the Australian and New Zealand College of Anaesthetists, 'Lives of the Fellows: Michael Cousins', accessed 4 December 2022, https://www.geoffreykayemuseum.org.au/fellows/deans-of-the-faculty-of-pain-medicine/michael-cousins/.

[10] Lesley Brydon, interview by GKD, 8 April 2019.

Ultimately, Cousins reluctantly conceded, agreeing to move ahead with more 'acceptable' terminology for chronic pain as a chronic condition in its own right, rather than as a disease entity.

Nevertheless, despite its being a contested concept, Skinner supported the recognition of chronic pain as a chronic disease. In 2013, she led a move by the states, territories and the Commonwealth to have the notion accepted, and told Australia's Standing Committee on Health that such a move would improve treatment and access to services for the one in five Australians who struggled with chronic pain. Recognising chronic pain as a chronic disease, she avowed, would bring it into line with other diseases and validate it as a disease in its own right, not just a secondary disease or a symptom of something else. 'This recognition is essential so patients are identified earlier and can access the appropriate care they need.'[11]

In mid-2012, Skinner asked Cousins to host a press conference at RNSH. Thinking the minister would use the occasion to promote the activities of the taskforce, he agreed. Instead, Skinner announced that the New South Wales Government had allocated $26 million over four years to fund the *NSW Pain Management Plan*.[12] Cousins was speechless, not realising that the minister's Cabinet colleagues had agreed to fund the plan. Skinner told the assembled journalists that the plan focused on integrating interdisciplinary pain management across all levels of the state's health system. 'I believe this is groundbreaking', she said, 'because it's the first time I'm aware of anywhere that there has been such a coordinated focus on pain management. It recognises this as an important chronic condition that has just been ignored.'[13]

The plan also included pain education, training and workforce development for health professionals, community-wide strategies to reduce the stigma of chronic pain and better access to early intervention. When Skinner announced extra funding for PMRI, Cousins remembered his heart 'skipping a beat'. The government had approved grants for PMRI to boost its research,

[11] Jillian Skinner, 'NSW Leads National Bid to See Chronic Pain Recognised as a Disease', media release, 14 June 2013, Jillian Skinner Private Collection.

[12] Jillian Skinner, 'An Overhaul for Pain Management in NSW', media release, 18 July 2012, Jillian Skinner Private Collection.

[13] Jillian Skinner, 'An Overhaul for Pain Management in NSW'.

clinical services, the ADAPT program and postgraduate education.[14] Skinner recalled that Cousins almost 'burst into tears'.[15]

Around the same time, Jane Cousins gave birth to a son. Cousins and Michele were thrilled and flew to Milwaukee to stay with Jane, Charlie and baby Henry. Cousins loved being a grandfather. Jane said he was wonderful with Henry and incredibly patient:

> When Henry cried, Dad walked around the house with him nestled against his chest, gently tapping his back. He'd just walk and walk, doing laps and wearing holes in the carpet. He was definitely hands-on and loved being able to help me. He cherished that special time in our lives.[16]

Two years later, in 2014, Cousins turned seventy-five. Though he was desperate to retire from RNSH, no-one wanted his job. Early that year, he received one of the nation's highest honours—an Officer of the Order of Australia—for 'distinguished service to medicine through specialised tertiary curriculum development, as a researcher and advocate for reform and human rights in the field of pain, and as an author and mentor'.[17] Honoured by this recognition, he said 'it truly belonged to everyone who had collaborated to advance pain medicine in Australia'.[18]

Several journalists asked Cousins about his proudest achievement: 'Setting up the Faculty of Pain Medicine', he told them.[19] Leigh Atkinson, who claimed Cousins 'was the driving force bringing multidisciplinary medicine into this country', agreed. 'Setting up the faculty was a one-in-a-million skill, and it got people focused on chronic pain.'[20] Stephan Schug, a professor of anaesthesiology at the University of Western Australia, said that before FPM existed, no-one saw pain as a priority. 'FPM made pain visible to everyone and gave the pain medicine community power; it created political pressure for improvements in the system. Pain is

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[14] The NSW Pain Management Plan included $735,000 per annum for PMRI's education programs, as well as basic and clinical pain research. Skinner, 'An Overhaul for Pain Management in NSW'.

[15] Skinner, interview.

[16] Jane Cousins, interview by GKD, 7 January 2021.

[17] Australian Government, 'Officer of the Order of Australia', Australia Day 2014 Honours List, 26 January 2014, https://honours.pmc.gov.au/honours/awards/1148828.

[18] MJC, interview by GKD, 28 September 2019.

[19] Clifford Fram, 'More to Beating Pain than Pills: Professor', *AAP*, 11 February 2014.

[20] Leigh Atkinson, interview by GKD, 1 October 2019.

something governments, insurance companies and the international community now talk about, and the Faculty of Pain Medicine got the ball rolling.'[21]

'Pain medicine specialists now have a seat at the table', Goucke remarked, 'and the federal government continually seeks inputs on policy from them, especially on issues surrounding the use of opioids'. For Goucke, the problem now is that FPM is often 'snowed under' with requests for input on many policies, which means it has to be agile to meet the government's short deadlines. 'It's now or never', he said. 'At least we're part of the conversation. That would never have happened without the Faculty of Pain Medicine. Pain medicine has a voice, and we can now influence health policy and Medicare numbers.'[22]

Cohen, who represented physicians on the original faculty board, viewed Cousins as a highly esteemed captain of the ship. 'Without Michael's initiative, energy and political influence, the faculty would not exist. Once Michael launched the ship, there were several lieutenants, and I count myself fortunate to have been one of them', Cohen remarked. 'I think it's important to acknowledge the role of the captain.'[23] FPM's current dean, Dilip Kapur, suggested that the faculty is the envy of the pain world:

> It's an astonishing thing that it started here in Australia, and everybody else who's tried to build a model since, has followed the same model, and it was Michael's model. Michael has been described as a visionary. I think he's more than that. I think Michael had something that was quite transcendent in that he understood exactly where we needed to go, to have people who were fully trained to understand the predicament that our patients were suffering, those with chronic pain.[24]

In February 2014, RNSH renamed its pain centre the 'Michael J. Cousins Pain Management and Research Centre' to honour Cousins's contribution to pain medicine during his fifty-year career.[25] By that stage, he had helped thousands of patients, and published 236 scientific papers in collaboration with colleagues.[26]

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[21] Stephan Schug, interview by GKD, 23 October 2019.

[22] Goucke, interview.

[23] Cohen, interview.

[24] ANZCA, *A Tribute to Michael Cousins*.

[25] Jillian Skinner, 'RNSH Renamed in Honour of Professor Michael Cousins', media release, 11 February 2014, Jillian Skinner Private Collection.

[26] Russo, 'The Michael J. Cousins Lifetime Achievement Award'.

In his speech at the renaming event, Cousins once again acknowledged the Herculean efforts of the pain centre's team in contributing to its success. 'Thanks to all PMRI staff who helped me realise my vision. PMRI represents more than anything else what I've been attempting to bring to fruition over the past twenty-three years in Sydney, and over the prior fifteen years in Adelaide.'[ii]

When a journalist asked him how he felt about the pain centre being named in his honour, Cousins replied: 'It's a mixed feeling. I'm pleased my efforts have been noticed. But there's a long way to go. Chronic pain is the next major illness in Australia after depression.'[27]

The following year, he was delighted when his son Chris became a father to twins—Richard and Mila. After the birth of his twins, Chris took a year off work to look after them. Cousins wished he too had taken a break to spend time with Jane and Chris when they were born. He regretted being so preoccupied with professional commitments when his children were young.

The year after Chris's twins were born, Cousins retired from RNSH. He was bone-tired and had wanted to leave years earlier, but it took three rounds of interviews before a replacement was appointed.[28] He was relieved when the renowned palliative care clinician Paul Glare accepted the role.

On 19 May 2016, Cousins's last day at RNSH, the pain centre hosted a festschrift presentation to celebrate his contributions. Skinner, pain centre colleagues, and leading pain medicine experts from Australia and worldwide paid tribute to him during the event.

In his speech, Brooker said that Cousins's vision for the future was unique. 'First, he has an idea. Next, one hears the idea mentioned, and seemingly overnight, it just happens.' Brooker listed the many textbooks Cousins wrote or co-edited, the two hundred journal articles he co-authored, the NHMRC Centre of Excellence, ADAPT, the master's courses, the recognition of pain medicine as a specialty, FPM, the National Pain Summit, the *National Pain Strategy* and the *NSW Pain Management Plan*. Brooker noted that it all seemed effortless, yet all these things dramatically impacted the availability of care for patients. He also mentioned how he had

[27] Fram, 'More to Beating Pain than Pills: Professor'.

[28] Johnston, interview, 12 September 2023.

appreciated the chance to learn from Cousins how to survive hostile hospital meetings about funding—'a dark art!'[29]

The event concluded with Cousins receiving a festschrift book chronicling his achievements.[30] As he accepted it, he said:

> Being exposed to people like John Bonica stimulated in me a great sense of responsibility to the field of pain medicine and to the patients I treated. I'm always trying to decide whether I'm meeting my obligations to the field of pain medicine and my patients. It's immensely satisfying to be able to treat patients whom no-one else could previously help—it's not only satisfying, it's exhilarating! I think it's a field that's enormously demanding. It's incredibly debilitating sometimes to deal day after day with patients for whom sometimes you can do nothing. It can sometimes grind you down. But the potential rewards are very great, and I think it's a wonderful area of medicine to practice, no doubt about it.[31]

While New South Wales was the frontrunner in introducing a statewide pain plan, other states soon followed. Despite changes of governments and health ministers reducing the priority given to pain management in some states, repeated surveys reveal that access to pain management services has improved, though not consistently across the country.[iii] Several online resources are now available for people who cannot access a public pain clinic or an affordable pain specialist,[32] and support groups for people with chronic pain have emerged across Australia.[33]

After launching the Declaration of Montreal, Cousins's advocacy for access to pain management to be viewed as a human right gained currency. Paediatric pain specialist Susie Lord said that acceptance of pain management as a human right was 'game-changing' and

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[29] Brooker, 'A Festschrift Presentation in Honour of Michael J. Cousins AO'.

[30] John Parker, 'A Festschrift Presentation in Honour of Michael J. Cousins AO', 19 May 2016, MJC Private Collection.

[31] MJC, 'Speech Notes', A Festschrift Presentation in Honour of Michael J. Cousins AO, 19 May 2016, MJC Private Collection.

[32] One example is the Agency for Clinical Innovation Pain Management Network, which helps people better manage their pain. It also includes resources to educate general practitioners. See Agency for Clinical Innovation, 'Pain Management Network' [website], accessed 5 January 2020, https://www.aci.health.nsw.gov.au/chronic-pain.

[33] Painaustralia lists contact details for support groups on its website. Painaustralia, 'Patient Support Groups around Australia', 2020, https://www.painaustralia.org.au/find-support/care-in-community-1/painaustralia-support-groups-help-lines.

strategic thinking of the highest level. 'It's made such a difference for patients, not just in Australia and New Zealand, but everywhere.'[34]

The World Medical Association endorsed the Montreal Principles in 2011, resulting in the International Federation of Health and Human Rights Organizations making it one of its top two priorities.[35] WHO now supports the concept, raising its emphasis on pain management in its global health programs.[36] And the European Pain Federation's *Societal Impact of Pain* platform, the United States Institute of Medicine's *Relieving Pain in America* report and the US *National Pain Strategy* also referenced the declaration.[37]

Like many leaders, Cousins always focused on the end game rather than the small steps along the way. Notably, he depended on his talented colleagues to complete the many projects he initiated. Clearly, his audacity and ambition enabled him to drive an uncompromising agenda. Perhaps these traits and a crusade-like approach are what it takes to bring about reform of treatment protocols, national health policies, institutions and attitudes? Though much more advocacy for health system reform is required to provide access to pain management services for everyone who needs them, Cousins's relentless, single-minded approach indisputably advanced pain medicine in Australia and around the world.

While Cousins's legacy is difficult to measure because so much more is required to provide equitable access to pain management services, several indicators suggest the significance of his contributions. His legacy might be thought of as essential building blocks, the infrastructure required to construct a sustainable system of pain management.

One indicator is that, like Bonica, Cousins taught, mentored and inspired new generations of pain medicine professionals in Australia and overseas. This is crucial because a highly skilled pain medicine workforce is the cornerstone of pain medicine practice. Throughout his career, he trained dozens of Australian and more than seventy-five international pain medicine fellows.

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[34] ANZCA, *A Tribute to Michael Cousins*.

[35] Medical Human Rights Network, 'Pain Treatment', accessed 20 November 2022, https://www.ifhhro.org/topics/pain-treatment/.

[36] Strong, 'Nomination for Professor Michael J. Cousins, Council for the Order of Australia'.

[37] Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education. *Relieving Pain in America: 'A Blueprint for Transforming Prevention, Care, Education, and Research'*. Washington: National Academies Press, 2011, https://pubmed.ncbi.nlm.nih.gov/22553896/; United States Interagency Pain Research Coordinating Committee, *National Pain Strategy* (Washington: National Institute of Health, 2016), https://www.iprcc.nih.gov/National-Pain-Strategy/Overview; European Pain Federation, 'The Societal Impact of Pain', accessed 9 March 2021, https://www.sip-platform.eu/en.

Remarkably, by 2013, he had trained pain medicine fellows from twenty countries. He also assisted in establishing pain medicine centres throughout the Asia Pacific region and in Europe, Canada and America.[38]

The psychologist, Ross Harris, who worked with Cousins for nearly three decades, described his legacy in two columns. The first related to his personal strengths and the other was his professional competence.

Harris was astounded by Cousins's remarkable energy and his ability to 'get people excited and bring them along with him'. Knowing he could not do everything himself, he delegated. A quality Harris particularly appreciated was Cousins's habit of always being 'present' when speaking with someone:

> In all my experiences with Michael, there was never a time that I felt his attention was elsewhere. He was always fully in the moment, and able to develop a strategy to make best use of that moment. That's leadership. He was very measured and consistent in his leadership approach. I appreciated his eloquence, calm demeanour and authority.

On the clinical front, Harris admired Cousins's emphasis on excellence of clinical care and insistence on team members continually improving their skills with the 'aim of the patient not being left to struggle alone but feeling that they were supported by a care team'. Harris also appreciated how Cousins encouraged pain centre staff to 'advance, assist and strengthen other members of team'.

The second element of Cousins's professional contribution, according to Harris, was putting in place a model of excellent scientific research along with Laurie Mather and nurturing others to pursue multidisciplinary research. 'Michael relentlessly pursued novel approaches for treating pain and he continuously drove the science of pain medicine', Harris remarked. 'He set a high bar for pain research, pain education, training in pain and for advancing the field globally.'

Cousins's lasting legacy, Harris believed, was to have rapidly brought Australia into the arena of international pain research and pain management practice: 'Michael was a person who was

[38] James Strong, 'Nomination for Professor Michael J. Cousins', Council for the Order of Australia, 2013, MJC Private Collection.

equally at home in the international arena and at RNSH when he sat talking with patients empathising with them about the misery their injury or condition had created for them.'[39]

One of Cousins's striking characteristics was the way he compartmentalised his life. With bureaucrats, politicians and sometimes the medical profession itself, he was a tough negotiator and fiercely determined to achieve his goals. Yet, with his family, friends and patients, he was warm, kind, calm and empathetic. Patient after patient noticed and appreciated his habit of worrying about them until he found a solution to reduce their suffering. His tireless devotion to his patients was captured by a memory Symantha Liu related that involved a hospital ward and a tuxedo. Symantha had been suffering with a cluster migraine for several days. When the pain became unbearable, Cousins admitted her to RNSH. As she became increasingly distraught, Symantha felt a gentle hand on her shoulder and heard a soft voice say: 'Sam, it's me, Michael Cousins.'

Through her tear-stained eyes and blotchy vision, she struggled to make him out. Slowly, a man wearing a dashing dinner jacket and with dapper silver hair came into view. Cousins told Symantha he was there and not to worry. She asked him why the hospital had disturbed him if he had somewhere important to be. 'Whenever I feel one of my patients has reached a migraine crisis, I can only feel better if I lay eyes on them for my own peace of mind', he said.

Symantha said this is the 'measure of the man. For me, forever, a saint on earth.'[40]

[39] Harris, interview.

[40] Liu, interview.

Epilogue

Following his retirement from RNSH, Cousins missed his colleagues, many of whom were lifelong friends. However, he was relieved to never again sit in a meeting with a hospital administrator. Marc Russo recalled that one way Cousins 'kept his cool' during protracted evening meetings about funding was to pour a nip of Johnny Walker Black Label Whisky into a glass and slowly sip it. 'It helped him endure those whose verbiage exceeded their intellect.'[1] With those frustrating meetings a distant memory, Cousins truly embraced leisure for the first time in his adult life, combining it with seeing patients at a private pain clinic. Catching gigantic waves on his surf ski at Palm Beach filled many days, as did playing golf with Michele and spending time with his grandchildren. He also relished the chance to read novels and biographies and watch the Wallabies play rugby.

Unfortunately, this sense of freedom was short lived because, shortly before his eightieth birthday, he was diagnosed with Parkinson's disease. It was a devastating blow, and he regretted not retiring earlier when he was in robust health. While his habit of navigating around roadblocks had served him well during his career, Parkinson's was less amenable to negotiation and charm. It was a formidable obstacle, yet, in true Michael Cousins's style, he tenaciously applied himself to living the best life he could despite his illness.

A few days after Cousins's death on 27 April 2024,[2] ANZCA interviewed several of its members about his legacy. 'Michael was a visionary leader, and most of what we're doing today for patients is based on his ideas, things he put forward', long-term RNSH colleague Charles Brooker said. 'He was always focused on patient outcomes and fostering improvements. He had so many good ideas and most of them he was able to put into practice to demonstrate to the rest of us how you can do that, how you can actually take an idea and get it to happen.'[3]

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[1] Russo, interview.

[2] Gabriella Kelly-Davies, 'Cousins, Michael John (1939–2024)', Obituaries Australia, National Centre of Biography, Australian National University, accessed 13 July 2024, https://oa.anu.edu.au/obituary/cousins-michael-john-34409/text43192.

[3] ANZCA, *A Tribute to Michael Cousins*.

Kieran Davis, FPM's vice dean, agreed. 'Without Michael Cousins, there may have never been a Faculty of Pain Medicine, but definitely there wouldn't have been one when it happened', he stated, adding:

> In 1998, Michael Cousins decided there was going to be a faculty. Other people around him were saying: 'Please don't do it. It's too soon. We're not ready. We haven't got things organised.' And he said: 'No, things are ready, and we have to do it now.' And he took it to the ANZCA Council who said: 'We're not ready.' And he said: 'Nope, I'm not leaving this room. I'm going to keep talking. I am going to convince you all that now is the time.' And he did, and the faculty was formed. And he means everything to the faculty. He founded the faculty. He was the dean for the first three years to make sure that it got up and running and that all of the things that needed to be done were done. Thank you, Michael.[4]

While Cousins's achievements and awards are recorded in his lengthy resume, what is most crucial to recognise are the values underpinning them, values that were apparent to his family and friends when he was a small child. At his funeral on 3 May 2024, his younger brother Geoff presented several specific examples.[5]

Early on, Geoff noticed his older brother's unusual degree of empathy and compassion for classmates who were bullied at school or who looked lonely and sad. Cousins would search for ways to help the kids, including standing up to the bullies, befriending unpopular boys, and inviting them home to play after school and stay for dinner.

Geoff also recalled how, from the age of seven, Cousins would rebuke him if he was disrespectful or rude to their mother, Marjorie. He would draw Geoff aside and tell him to apologise to their mother and say something nice to make her feel happy. He also admonished his younger brother whenever Geoff misbehaved. Early on, Geoff noticed certain qualities in his brother that set him apart from the other young boys, though at the time he was too young to put a name to them. Now he can.

'The first is love', Geoff said, 'but it wasn't the common "I love you; you love me." It was a love of humanity. That's what was in him, a belief. He believed that all people are basically good and if some don't behave well, perhaps a little encouragement or support would cause them to do so.'

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[4] ANZCA, *A Tribute to Michael Cousins*.

[5] Geoff Cousins, 'Eulogy: Michael J. Cousins', 3 May 2024, Geoff Cousins, Private Collection; Geoff Cousins, interview by GKD, 3 May 2024.

The second quality Geoff mentioned was his brother's compassion. When Cousins noticed someone suffering, even in a small way, he felt a reciprocal sense:

> When those two things, love, which is the emotion, and compassion, which drives you to act, are present, it's a remarkably powerful combination, and that is what Michael had. No doubt, it was the combination of those two qualities that led him to pain management. My proposition to you is that while people believe Michael was a great man for his achievements, his greatness came from those fundamental qualities, not from the awards and the degrees.[6]

Figure 28: (L to R) Chris Cousins, Jane Kuehn, Max, Mila, Henry, Rich, Michael and Michele, Palm Beach, 2017.

Courtesy Michael and Michele Cousins.

Michael Cousins's two great loves were his family and medicine, and he was happiest when his family was gathered together at home.[7] Throughout his career, he found the thrill of a new medical discovery electrifying. Most of all, though, he loved helping people better manage their pain and reduce its impact in their life. His greatest wish was that Australia's *National Pain Strategy* would reduce suffering from pain, and that no-one would have to endure the horrific pain suffered by the two burned boys he treated at St George Hospital over fifty-five years ago.

[6] Geoff Cousins, 'Eulogy: Michael J. Cousins', 3 May 2024, Geoff Cousins, Private Collection.

[7] Jane Cousins, interview by GKD, 7 January 2021.

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Appendix: Supplementary Notes

Prologue

[i] In Australia, up until 1966, fireworks were let off to celebrate Commonwealth (previously Empire) Day.

Chapter One: Learning about Pain

[i] When Cousins was 14 years old, he worried that he did not yet know what career to pursue. He pestered his father Hedley for ideas. 'Dad, I should know by now what I'm going to do', he often said to his father. 'It takes a long time to make that decision', Hedley replied. 'It'll come to you when you're ready.' Michael Cousins, interview by GKD, 8 January 2019.

[ii] Hilton was a member of the Royal College of Surgeons in England, and he expressed novel ideas about how acute pain could interfere with, or help, people recovering from surgery. Michael Cousins, interview by GKD, 8 January 2019.

[iii] Cousins enrolled at Sydney Church of England Grammar School – Preparatory School ('Shore') in North Sydney in 1950 when he was eleven. Shore boys were taught to show initiative and leadership, and to be self-effacing and loyal to school, country and monarchy. G. G. E. Sherington, 'Robson, Leonard Charles (Len) (1894–1964)', *Australian Dictionary of Biography*, National Centre of Biography, Australian National University, published first in hardcopy 2002 then online in 2006, https://adb.anu.edu.au/biography/robson-leonard-charles-len-11550/text20609.

[iv] Geoff Cousins recalled his older brother as a conscientious student and extremely competitive. 'He was never competitive in an aggressive sense', Geoff said. 'He just wanted to excel at whatever he tackled.' Ray Chapman and Fergus Ryan also remarked on Cousins's competitiveness. 'Mike liked to win', Fergus said. 'He used to try very hard at everything he did.' Geoff Cousins, interview by GKD, 24 September 2019; Chapman, interview; Ryan, interview.

[v] Michael and Geoff went to Sunday School at the old sandstone Saint Martin's Anglican Church in Killara, and they accompanied their parents to church at Easter and Christmas. Religion, however, did not play a big part in their lives. Geoff Cousins, interview by GKD, 24 September 2019.

[vi] Often, when Geoff was naughty or rude to Marjorie, Michael would admonish him. 'You know, you really shouldn't do that', he would whisper. 'It's not the right thing to do. Say you're sorry to your mother.' Geoff Cousins, interview by GKD, 24 September 2019.

[vii] Keith Cousins was chair of George Patterson, Australia's largest advertising agency at the time, and president of the Advertising Federation of Australia. Geoff Cousins AM is a businessman, environmental activist, author and collector. Like his older brother Keith, he rose to chair George Patterson Advertising Agency and he was later the first CEO of the telecommunications company Optus Vision. He served on several not-for-profit boards, including the Starlight Foundation, Australian Conservation Foundation and Museum of Contemporary Art. Crawford and Dickenson, *Behind Glass Doors*, 67; David Naseby, 'Geoff Cousins', National Portrait Gallery, 2017, https://www.portrait.gov.au/portraits/2017.149/geoff-cousins.

[viii] Jackson Wain was formed in Sydney in 1946. Later, it opened offices across Australia, South-East Asia, New Zealand and London. Papers of George Crowley, 1964–1984, MLMSS 8284, State Library of NSW.

[ix] Ray Chapman and Fergus Ryan recalled that, from a young age, Cousins spoke eloquently and was persuasive. Whenever the boys were in trouble, Cousins had a habit of 'giving a honeyed version of the truth' to their parents who believed his version of events. Chapman, interview; Ryan, interview.

[x] Bonica's *The Management of Pain* was published in 1953 as a two-volume 1,500-word textbook. In the chapter on chronic pain, Bonica highlighted the differences between acute and chronic pain. 'Whereas in acute pain the pain is a symptom of the disease or injury', he wrote, 'in chronic pain the pain itself is the disease'. Bonica, *The Management of Pain*, 511.

[xi] This claim is an exaggeration because in 1958 the average failure rate in Cousins's class was thirty-three percent. However, it was what the medical students—over two-thirds of whom were male in the 1950s—claim

they were told on their first day at the University of Sydney. Catherine Storey, interview by GKD, 3 August 2022.

[xii] In an interview with Cousins on 17 August 2019, he asserted that the dean, Bruce Mayes, told new medical students to: 'Look around carefully on either side of you, because next year only one out of the three of you would be here.' Catherine Storey, the medical school's historian, insists this story is a myth, but it is so often told by medical students they believe it is true. Storey, interview by GKD, 3 August 2022. Still, failure rates were high in Australian medical schools. In the decade from 1955, failure rates in first year medicine averaged 27 percent and 45 percent in second year. In 1961, 35 percent of University of Sydney medical students failed one or more subjects. Ann Jervie Sefton, 'Chapter 1: The Faculty', in *150 Years of the Faculty of Medicine*, ed. Yvonne Cossart Ann Jervie Sefton, Louise Freckelton (Sydney: Sydney University Press 2006), 8.

[xiii] Weekday shifts involved arriving at the hospital at seven o'clock in the morning, treating patients until seven o'clock in the evening, then doing the night shift, followed by another full day of work. Weekend shifts started at seven o'clock on Saturday morning and ended on Monday evening. Storey, interview by GKD, 21 September 2022.

[xiv] As well as funding a year in Montreal, the travel grant funded visits to medical centres in England, Europe, Asia, the Middle East and Scandinavia prior to Cousins taking up the appointment at McGill. He also took part in the final fellowship course of the Royal College of Surgeons in London and visited Cecil Gray in Liverpool. Michael Cousins, 'Introduction: General Outline of Clinical and Research Background'.

Chapter Two: Montreal

[i] Apart from the addition of computers, surgical lights and modern medical equipment, the operating theatre remains in its original condition. On 25 May 2023, when I visited, it was not in use, so I was allowed to sit in it for an hour and absorb its aura. It is where Cousins conducted his first study on epidural anaesthesia in 1969.

[ii] IASP updated the definition of chronic pain in 2019, and it came into effect on 1 January 2022. The new classification of chronic pain includes seven diagnostic categories that are further divided into increasingly specific levels of diagnoses. The definition of chronic primary pain is: 'Chronic pain in one or more anatomical regions that is characterised by significant emotional distress (anxiety, anger/frustration or depressed mood) or functional disability (interference in daily life activities and reduced participation in social roles). Beatrice Korwisi et al., 'Chronic Pain in the 11th Revision of the International Classification of Diseases: Users' Questions Answered', *Pain* 163, no. 9 (2022): 1675–87.

Chapter Three: Stanford

[i] Between 1971 and 1973, Cousins was the principal investigator on two research studies that investigated methoxyflurane metabolism and its role in kidney toxicity and an associate investigator on six studies. MJC, 'Curriculum Vitae: Professor Michael Cousins AO', 2016, Cousins, Medical Biographies Collection.

[ii] In 1972, Cousins was appointed as a consultant to the US Food and Drug Administration, Respiratory & Anesthetic Drug Advisory Committee. Richard Crout to F. R. Margarey, 27 August 1973, Cousins, Medical Biographies Collection.

[iii] John Bonica empathised with the war veterans because he, too, suffered from unrelenting pain after a career as a professional wrestler while a medical student. By March 1985, he had undergone twenty-two surgical procedures within a period of twenty-five years, some of which left him in a body cast from chest to ankles for several months at a time. JJB to Harold Merskey, 6 March 1985, Box 4 Folder 124, Bonica Papers.

[iv] Multidisciplinary pain management is provided by practitioners from different disciplines. Each professional works separately, with their own therapeutic aim for the patient. In comparison, interdisciplinary pain management is provided by practitioners from different disciplines who collaborate in the assessment, treatment and ongoing review of patients using a shared biopsychosocial model and goals. IASP, 'Terminology', accessed 27 August 2022, https://www.iasp-pain.org/resources/terminology/.

[v] Louisa Jones said Bonica eventually 'drove each secretary nuts'. One day the university's personnel officer called Jones to a meeting and asked why Bonica could not keep his secretaries longer than he did. Jones, interview.

[vi] Louisa Jones said she learned very early in her relationship with Bonica to sit down as soon as she stepped into his office. 'He didn't want you hovering over him.' Jones, interview.

[vii] Delegates heard eighty-nine papers on the subject of pain. The accommodation in the former convent was basic with old steel framed single beds and shared bathrooms. It was so isolated that everyone mingled and chatted until the early hours of the morning, forging close bonds and becoming members of Bonica's 'famiglia'. Liebeskind and Meldrum, 'John J. Bonica, World Champion of Pain', 29.

[viii] In 1972, Cousins and Mazze drafted a chapter, 'Renal Diseases in Relation to Anesthesia' in the book: J. Katz, B. Jonathan and B. K. Leslie, *Anesthesia and Uncommon Diseases: Pathophysiologic and Clinical Correlations* (USA: W. B Saunders, 1981). They also drafted two chapters on the biotransformation of methoxyflurane in Gianfranco Dal Santo, *Biotransformation of Local Anesthetics, Adjuvants, and Adjunct Agents* (Boston: Little, Brown and Company, 1975). Between 1970 and 1973, along with other collaborators, they published nineteen research articles and submitted another three for publication. Nine letters to the editor were also published in US newspapers during this period. Michael Cousins, Bibliography, 1973, Cousins, Medical Biographies Collection.

[ix] Philip Bromage wrote in a letter of recommendation:

> Dr Cousins has been approached by many departments in the USA and Canada, including my own, but his first loyalties are to his own country, and that is where he would prefer to work, if he can find the right outlet for his abilities and professional interests. I am confident that his unusual gifts will enable him to meet the challenge of a research directorship with great distinction. Phillip Bromage to F. R. Magarey, 9 July 1973. Cousins, Medical Biographies Collection.

Philip Larson, professor and chairman of Stanford's anaesthesia department, wrote: 'Naturally, we are disappointed that Dr Cousins has decided to return to Australia. He feels this responsibility strongly, and we support his decision. However, we do expect to maintain a close research affiliation with Dr Cousins.' Philip Larson to F. R. Magarey, 9 July 1973, Cousins, Medical Biographies Collection.

[x] Cousins asked his bosses and colleagues to indicate their estimation of his ability to carry out research studies in the reference letters they wrote. Crout to F. R. Margarey, Cousins, Medical Biographies Collection.

[xi] The following are excerpts from several referee reports for Cousins's job applications.

Philip Bromage wrote: 'Dr Cousins is an exceptionally outstanding individual, with great drive, dedication and singleness of purpose. His ability lies behind a quiet low-key personal charm, that is refreshingly free of self-advertisement.' Bromage also noted Cousins's 'ability to get the most out of people—not by pushing or cajoling, but by the leadership of his infectious enthusiasm and tireless energy' and his qualities: 'wide vision, steadfast purpose and stamina, with warm good humour, and clinical and laboratory expertise in several disciplines'. Phillip Bromage to F. R. Magarey, 9 July 1973. Cousins, Medical Biographies Collection.

Gordon Robson wrote: 'Dr Cousins has certainly proved himself to be a young man of ability in a hurry and has had an impressive output of first-class research in a very short time.' Gordon Robson to F. R. Margarey, 3 August 1973, Cousins, Medical Biographies Collection.

[xii] During Cousins's visit to the Virginia Mason Medical Center, he and Bridenbaugh created an outline for each chapter, then invited experts from Australia and around the world to write them. From then on they embarked on a frenetic schedule of weekend conferences to explore the latest developments in pain medicine and regional anaesthesia.

Chapter Four: The Tug of Home

[i] At McGill and Stanford, Cousins said he had learned to identify a clinical problem, design a research study to explore the issue, then apply insights gained from the research to patient care. At RNSH, however, different departments managed research and the treatment of patients, and as an assistant anaesthetist, Cousins's role was to provide anaesthesia and intensive care services; research was the domain of the hospital's professors rather than its clinicians. Reeve, interview.

[ii] The article mentioned Cousins's experience in North America, including regional anaesthesia research with Philip Bromage, 'a world authority in the field' and the toxicology research he conducted with Mazze. It also

noted that the Scandinavian Society of Anaesthetists had invited Cousins to present a paper at a drug interaction symposium the following year and that the chairman of the congress had invited Cousins to serve as a visiting professor to his university while at the symposium. Further, the article noted that Cousins would continue his toxicology research at RNSH. In August 1973, Sydney University appointed Cousins as a research affiliate in the department of anaesthetics. R. B Fisher to Michael Cousins, 22 August 1973, Cousins, Medical Biographies Collection.

[iii] Also, Tom Reeve (interview) said:

> Michael got along well with everyone at the hospital, but the other anaesthetists thought he was different because he wasn't doing the things that they did. And that probably got up some of their noses; it meant more work for them. I never had a problem with him, but others did. Even though he didn't make waves and I never heard of anyone who wanted to crucify him—and there were plenty of colleagues whose enemies at the hospital did want to crucify them—some thought he was a bit of an upstart. But that's pretty easy in Australia; I mean, the guy went to McGill and Stanford. Nobody went to America in the 1960s; Australian doctors headed to England after they specialised. When you start to break away from traditions like that you create schisms and professional jealousy.

[iv] In 1973, Philip Larson had recommended to the American Association of University Anaesthetists that its leaders invite Cousins to join the association. In a letter of recommendation to the Kolling Institute, Larson wrote: 'With his impressive credentials, Dr Cousins will have little difficulty in being elected to membership.' Philip Larson to F. R. Magarey, 9 July 1973, Cousins, Medical Biographies Collection.

[v] The chairman of Flinders Medical Centre, Gus Fraenkel, wrote: 'This is the first Chair of Anaesthetics to be funded out of regular university funds in Australia.' Gustav Fraenkel to Sir Lincoln Hynes, 21 February 1975, Cousins, Medical Biographies Collection.

[vi] Australia's earliest pain clinic was established at the Queen Elizabeth Hospital in Adelaide in 1961 by the neurosurgeon Professor Donald Simpson. Patients were offered drug therapy, psychiatric services, physical medicine and regional nerve blocks. In 1962, Dr Brian Dwyer established a pain clinic at St Vincent's Hospital in Sydney. It had an initial emphasis on anaesthesia techniques and psychiatry and would later pioneer the treatment of people with chronic and cancer pain. Godden, *Australian Pain Society*, 33.

In 1964, Dwyer visited Bonica's pain centre at the University of Washington and, in a letter to Bonica, he included 'the first contribution on the treatment of intractable pain that has come from Australia'. Brian Dwyer to JJB, 22 July 1965, Box 2 Folder 93, Bonica Papers.

In 1967, the anaesthetist Tess Crammond set up a pain centre at Royal Brisbane Hospital in Queensland. Initially, the centre treated people with advanced cancer pain; however, it later offered services to people with chronic pain. In 1979, the neurosurgeon Leigh Atkinson co-founded a second interdisciplinary pain clinic in Brisbane at Princess Alexandra Hospital. Godden, *Australian Pain Society*, 33.

In 1976, the anaesthetist John Ditton conducted five sessions each week at Royal Prince Alfred Hospital in Sydney to develop a multidisciplinary pain service. This service began as an association with a neurosurgeon, John Segelov and a psychiatrist, Peter Beaumont. The unit also had dedicated pain nursing staff attached. Eventually funding was also obtained for a clinical psychologist, and an occupational therapist and physiotherapist joined the multidisciplinary team. Australian Pain Society, '2008 Distinguished Member Awards', John Ditton, accessed 1 March 2024, https://www.apsoc.org.au/PDF/Distinguished_Members/08_DISTMEMBawards_DITTON_J.pdf.

[vii] In an election policy speech, Don Dunstan, South Australia's then Opposition leader, laid out his vision if elected: 'South Australia will become the technological, the design, the social reform and the artistic centre of Australia … We'll set a standard of social advancement that the whole of Australia will envy.' 'The 1970s', State Library of South Australia, accessed 15 January 2024, https://www.samemory.sa.gov.au/site/page.cfm?u=360.

Chapter Five: A Fledgling

[i] Funding was allocated by Flinders University for Mather's and Cousins's positions, and the hospital paid the salaries of anaesthetists who worked in operating theatres and intensive care. Cousins had to raise money from

foundations, individual donors and grants from governments and the private sector for all other positions, both scientific and educational.

[ii] Tom Reeve agreed that Cousins used his 'old boys' network' to achieve his goals. 'He was thoroughly entitled to. And if he didn't use it to the maximum, I'd be surprised.' Reeve, interview.

[iii] Reflecting on John Bonica's dominating personality, Louisa Jones, IASP's executive secretary, said:

> To this day I have no excuse for not standing up for myself and saying 'no', except that 'no' was not a word he liked to hear. Dr Bonica had been a professional wrestler for a period in his youth, and I often heard others refer to this type of experience as the 'neck hold'; he simply waited for the muscles to relax and knew he had won. Jones, *First Steps*, 12.

[iv] The Australasian Chapter's focus was based on Bonica's model of multidisciplinary assessment and treatment of chronic pain. It also included an emphasis on scientific foundations, promoting interaction among basic scientists and clinicians, developing a common language (taxonomy) and developing undergraduate and postgraduate curricula. MJC, 'History of Pain Management: Developments in Australia and beyond', MJC Private Collection.

In 1982, anaesthetists represented thirty percent of IASP's members, followed by neurosurgeons (nine percent) then rehabilitation specialists (4 percent). L. Jones, 'IASP Membership Drive: Breakdown by Specialty', 12 August 1982, Box 55 Folder 53, Bonica Papers.

[v] Two weeks before arriving in Australia, Bonica wrote letters to several pain medicine professionals asking them to gather together 'scientists, physicians and health professionals interested in pain research and therapy for a meeting to discuss the latest pain research and treatments'. JJB to Sir Sydney Sunderland, 12 October 1978, Box 4, Folder 124, Bonica Papers; JJB to Issy Pilowsky, 12 October 1978, Box 4, Folder 124, Bonica Papers; JJB to C. Peck, 6 October 1978, Box 25, Folder 27, Bonica Papers.

Chapter Six: The Race to Advance Spinal Pain Relief

[i] Mather rationalised that pethidine should be a more effective drug because, unlike other opioids, it had a mild local anaesthetic action in addition to its morphine-like pain relief properties. Blood concentrations of pethidine were also readily measured. Mather, 'Stereopharmacological Research in Anaesthesiology', 32.

[ii] The Flinders study on delayed respiratory depression was the start of a series by the team to determine how delayed respiratory depression occurred. The researchers realised morphine migrated slowly up the spinal cord; it took about three hours to travel to the brain, then more time to penetrate deep enough into the brain tissue to affect the breathing centre. This slow migration was why some patients experienced depressed breathing about ten or twelve hours after receiving the morphine. Mather, interview by GKD, 14 April 2019.

[iii] Several leading pain researchers claim the Flinders studies profoundly influenced the development of epidural pain relief in patients with acute, chronic and cancer pain. A. Basbaum, 'Michael J. Cousins Doctor of Science Thesis, Examiner's Report', University of California, San Francisco, 2006; Loeser, interview, 28 September 2019; Dan Carr, interview by GKD, 18 July 2019; Kathleen Foley, interview by GKD, 26 September 2019.

[iv] The May 1979 scientific meeting included scientific and clinical sessions with speakers such as Tony Yaksh from the Mayo Clinic, Sir Sydney Sunderland (peripheral nerve pain), Arthur Duggan (spinal cord mechanisms in control of pain), Issy Pilowsky (psychiatric aspects of pain), Laurie Mather and Chris Glynn. MJC, 'IASP Newsletter: Chapter Activities', February 1980, Box 55 Folder 48, Bonica Papers.

[v] The John Mitchell Crouch Award is granted to an individual who, in the opinion of the Council of the Royal Australasia College of Surgeons, is making an outstanding contribution to the advancement of surgery or anaesthesia or to fundamental scientific research in these fields. Margaret Boult et al., 'Looking back at the John Mitchell Crouch Fellowship: The Most Prestigious Research Award of the Royal Australasian College of Surgeons,' *ANZ Journal of Surgery* 85, no. 10 (2015): 707.

[vi] In a letter to Harold Merskey, chairman of the Taxonomy Subcommittee, Bonica wrote:

I plan to lock the Taxonomy Committee in a room and will not let anyone out until the Committee hammers out some basic aspects of taxonomy and classification! I'm very serious about this and believe it is the only way that we can overcome the great psychologic hurdle that most people in the field have: 'It's impossible to develop a

taxonomy and classification on pain because it will not be acceptable to all.' JJB to Harold Merskey, 24 April 1978, Box 4 Folder 124, Bonica Papers.

[vii] Louisa Jones challenged the claims of Glynn, Cherry and Gourlay. 'Michael had a lot of his own ideas; he didn't need to borrow other people's ideas.' Jones, interview. Reeve shared a similar view. One of the things he had first noticed about Cousins when they met in the 1960s and something he believed distinguished Cousins from his colleagues, was his frequent habit of suggesting innovative ideas for research, so much so Reeve labelled his younger colleague an 'ideas man'. Reeve, interview.

Chapter Seven: Surging Interest in Pain Medicine

[i] Keynote speakers included John Liebeskind, Connie Peck, Arthur Duggan, James Lance and Nikolai Bogduk.

[ii] The registration fee for the meeting was $10 and delegates slept at the university colleges to reduce accommodation costs. Flinders University provided lecture theatres for free and pharmaceutical companies provided sufficient funding to partially offset costs. MJC, interview by M. Meldrum, 30.

[iii] Bonica retired as the University of Washington's chair of anaesthesia in 1978. Disappointingly, with his departure, the funding he had attracted evaporated. After the university withdrew the pain centre's funding, Cousins wrote a letter to its president, John R. Hogness, protesting the decision. 'He didn't even write back to me', he attested. 'So that was very, very sad, to see that wonderful facility, plus several top-class people, go into decline.' Michael Cousins, interview by Gabriella Kelly-Davies, 24 June 2019.

[iv] Michael MacKellar was the federal minister for health from 1979 to 1982 in the Fraser government. Mackellar was one year ahead of Cousins at Shore School, so it is possible he agreed to the invitation to speak because of this connection.

[v] John Cornwall was South Australia's health minister for six years from 1982. He set out to radically reform the state's approach to health. In his political memoir, *After Work, after Play, after All*, he wrote: 'I was anxious to broaden public discussion in order to foster community involvement in a system that redefined health as a state of physical, emotional and social well-being, not just as he absence of disease.' John Cornwall, *After Work, after Play, after All: A Political Memoir* (Adelaide: Bookpod, 2017), 149.

[vi] The funding enabled Cousins to set up a research team that included professionals from a variety of disciplines, including biochemists, experimental and clinical pathologists, and physicists. He also established a team of doctors, nurses, physiotherapists, social workers, rehabilitation specialists and psychologists who provided pain management services.

Chapter Eight: Global Ascendency

[i] Bonica's 'Scrapbook' in the Bonica Papers at UCLA contains hundreds of magazine articles, newspaper clippings, awards, press releases and photographs pertaining to Bonica, who always sought publicity for the pain field in order to draw attention to this 'disease state of major national importance'. Bonica (John. J) Papers, accessed 20 July 2023, https://oac.cdlib.org/findaid/ark:/13030/tf4t1nb37b/dsc/#aspace_ref30_6bq.

[ii] An eponymous oration is one named after a prominent person. In medicine, it is usually someone who has made a breakthrough scientific discovery or pioneered a new technique or field of medicine. Harris, Nagy, and Vardaxis, *Mosby's Dictionary of Medicine,* 622.

[iii] In 1981, at St Peter's Square in Vatican City, a would-be assassin had shot Pope John Paul II. One of John Bonica's close friend, the anaesthetist and IASP member, Professor Corrado Manni, was the pontiff's anaesthetist during surgery to remove the bullets. Manni also served as the Pope's pain physician postoperatively. Jones, *First Steps*, 24.

[iv] Cousins's agenda included implementing the curriculum in pain management that Howard Field had developed, increasing the research content of the journal *Pain*, strengthening IASP's relationship with the World Health Organization and contributing to the World Health Organization's global cancer pain program. He also mentioned his intention to introduce refresher courses and increase the research content of pain congresses. J. Loeser, 'Minutes: IASP Council Meeting', Hamburg, 6 August 1987, Box 55, Folder 59, Bonica Papers.

[v] San Francisco's leading newspaper, the *San Francisco Chronicle*, frequently published articles about AIDS and the desperate need for new hospitals to cope with the scale of the crisis. 'It took the shine off living in the free atmosphere of the west coast of America for us', Cousins recalled.

[vi] In October 1987, the American Society of Regional Anesthesia and Pain Management accepted a US$12K grant from Pharmacia Deltec for a period of ten years to support a John Bonica Lecture on Pain. J. Robins, 'The American Society of Regional Anesthesia and Pain Management Archive', finding aid, 6 August 2012, https://www.woodlibrarymuseum.org/wp-content/uploads/archives/ASRA%20II%20FA.pdf.

[vii] Cousins delivered the J. J. Bonica Distinguished Lecture at the 13th Annual Meeting of the American Society of Regional Anesthesia and Pain Management on 17 March 1988 in San Francisco. He suggested the benefit of an acute rehabilitation team was it enabled patients to easily access psychologists, community nurses, physiotherapists and occupational therapists. He said doctors could maximise pain relief and minimise the overall dose of pain medication by administering analgesics by several routes simultaneously. MJC, 'Acute Pain and the Injury Response: Immediate and Prolonged Effects', *Regional Anesthesia & Pain Medicine* 14 (1989): 162–78.

[viii] On 1 July 1989, when Loeser, his wife Karen and four-year-old son David arrived in Adelaide, Cousins and Michele 'adopted' them. 'The Cousins made sure everything went smoothly for us', Loeser said. During his sabbatical, Loeser spent one day each week in FMC's pain clinic and the rest of the time researching pain medicine in FMC's library. Every Wednesday afternoon, he and Cousins focused on implementing IASP's far-reaching agenda, developing guidelines for pain treatment and expanding the journal *Pain*. They valued their time together and fast-tracked several priority projects. Loeser, interview, 21 April 2019.

While in Adelaide, Loeser and Cousins collaborated on a study of different rates of spinal surgery in various regions of South Australia. It showed an unexplained fourfold variation in the rate of spine surgery in sixteen healthcare regions. The results were controversial, and the orthopaedic surgeons tried to stop Cousins and Loeser from publishing them. John Loeser et al., 'Small Area Analysis of Lumbar Spine Surgery in South Australia', *Australian and New Zealand Journal of Surgery* 63 (1993): 14–19.

[ix] Cousins and his IASP colleagues mostly corresponded by telephone and fax rather than letters, apart from Bonica, who was a prolific letter writer. Louisa Jones kept copies of the letters Bonica sent and received, though she said no-one thought to keep notes of phone calls or save faxes for the historical record, making it challenging to corroborate verbal testimony.

Chapter Nine: Starting Over

[i] In late 1990, when the Cousins returned to Sydney, Australia was in the grip of what Prime Minister Paul Keating called 'the recession we had to have'. The State Bank of South Australia had crashed, so borrowers could not access funds to purchase a new house, leaving Highfield unsold until late 1991. Tom Connors, 'The Jobless High We Had to Have', *Canberra Times*, 14 December 1990, 1; Glen Giles, 'State Bank Crashing Around Bannon's Ears', *Tribune*, 20 February 1991, 3.

[ii] The Northern Sydney Area Health Service promised an annual budget of $750,000 (equivalent to $1.5 million in 2020). In January 1991, the director of RNSH's medical services Hilary Barton wrote:

> As was expected, it has been a costly exercise fulfilling our promises and I am unsure if in our present financial situation we are going to be able to 'afford' all of it this financial year. I believe we will have to delay the commitment of $100,000 to the Trust Fund until next financial year. Hilary Barton to MJC, 17 January 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

In April 1991, Stuart Spring wrote: 'I believe the Hospital has fulfilled all its commitments to date to establish the new Department to the standard you desire at a cost considerably in excess of that anticipated in the original planning.' Spring to MJC, 4 April 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

Still, another $700,000 was required to complete the clinical research facilities, and an extra $300,000 was needed for research equipment and other research infrastructure. In September 1991, Spring reminded Cousins that $179,265 had been approved in April 1991 for the purchase of research equipment for the 1990/1991 financial year. Spring to MJC, 18 September 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

See also, S. Spring to MJC, 9 May 1990, MJC Private Collection and MJC, 'Appeal for the Anaesthesia and Pain Management Research Centre', newsletter no 1, August 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

[iii] In October 1991, Spring wrote: 'As you are aware the economic climate has changed considerably. As such it is no longer possible to guarantee such ongoing [budget] flexibility.' S. Spring to MJC, 14 October 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2 (original emphasis).

[iv] The aim of the first meeting of the steering committee on 27 May 1991 was to identify individuals to join the steering committee, form an appeal committee and:

> identify senior executives in major companies who are known to them and to whom they would be prepared to introduce to Professor Cousins or Professor Mather. At the meeting, key prospects for donations were identified as: personal gifts and bequests from the community, gifts from 450 specialist anaesthetists in NSW and across Australia, major gifts from pharmaceutical and medical equipment companies and major gifts from non-medical companies, including, in particular, health and accident insurance companies.

At the meeting, it was announced that Pat Russell of Downes Venn & Associates had been appointed as the professional fundraising organisation for the appeal. The steering committee also met on 6 June 1991, 2 July 1991 and 23 July 1991. MJC, 'Summary of Activities of Steering Committee Appeal for Funds for the Chair of Anaesthesia and Pain Management', July 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

[v] The appeal board included Rick Turner (chair), Cousins, Mather, D. Nock, P. Gray (secretary), S. Ball, G, Crawford, P. Dickson, N. Full, B. Northam and A. Urquhart. P. Gray, 'Minutes of Appeal Board Meeting No. 1', 7 November 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

[vi] P. Gray, 'Minutes of Appeal Board Meetings', no. 2, 30 January 1992; no. 4, 26 March 1992; no. 5, 28 April 1992; no. 6, 27 May 1992; no. 7, 30 July 1992; no. 8, 3 September 1992; no. 9, October 1992; no. 10, 26 November 1992, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

[vii] Pain medicine pioneers such as Bonica, Melzack, Wall, Loeser and Oxford University's Professor Sir Keith Sykes provided testimonials in support of the centre, Cousins and Mather.

Bonica wrote: 'Professors Cousins and Mather have had an extremely impressive track record of highly productive research and they and their colleagues in Adelaide are regarded and respected for having one of the very best pain management and research programs in the world.' Bonica added that if Cousins and Mather received the necessary funding, space and personnel, the centre, because of their 'creativity, motivation and willingness to expend the necessary time and effort, the pain centre will become one of the most productive and prestigious such facilities in the world.' JJB, 'Letter of Support: Critical Need for Pain Management and Research Centre', 29 April 1992, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

Melzack wrote: 'Professor Michael Cousins and Laurence Mather are brilliant, dynamic leaders in the field of anaesthesia and pain management.' Melzack added that given their track record of excellence in Adelaide, Cousins and Mather 'deserve the funding to create an anesthesia department and pain clinic that will be the finest in Australia and one of a very small number of centers of excellence regarding pain throughout the world. They have gained extremely high standards for themselves and gained world recognition for their accomplishments.' R. Melzack, 'Testimonial', April 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

Wall wrote: 'Professor Cousins is one of only a small group of scientists and clinicians who have brought the treatment of pain from the doldrums to a period of enormous hope. Therefore his move to The Royal North Shore needs urgent full support because he has created a time of harvest where hard work in the right environment will certainly reap benefits.' Patrick Wall, 'Letter of Support for Fundraising Appeal', 22 April 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

Loeser wrote: 'There is no question in my mind that the two of you [Cousins and Mather] represent an unbeatable, dynamic duo and are a unique resource in your country. I know that major institutions in the United States, both public and private, have made strenuous efforts to recruit both you and Professor Mather to positions which would offer you much larger financial and institutional support.' J. Loeser, 'Letter of Support for Fundraising Appeal', November 1991, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 2.

[viii] Reeve said Cousins was a 'focused empire builder' in that he 'developed his own group, and he built it with Laurie Mather and others from outside the system. And that upsets these sorts of places, no question. He was focused on the pain clinic, and that was it. It didn't please some colleagues.' Reeve, interview.

[ix] Professor Duggan is an Australian research neuroscientist and a distinguished pain researcher. At the Eighth World Congress on Pain in Vancouver in 1996, Duggan met with Cousins, who asked him if he was interested in joining the RNSH pain centre on his return to Australia. Duggan agreed, taking up a part-time position as visiting professor to the University of Sydney in February 1998. While in Edinburgh, Duggan arranged for a 'fair proportion' of his laboratory to be sold for a very low price to RNSH's pain centre. It was shipped to RNSH soon after Duggan left Edinburgh. At RNSH, Duggan collaborated with Phillip Siddall on research into spinal cord injury pain. Cousins secured private research money to pay Duggan's salary and Duggan, Cousins and Siddall obtained an NHMRC grant for the research. Duggan said Cousins recognised the need for basic research and he worked hard to provide the space and money to support it. 'Michael certainly raised the international reputation of Australian research in the management of pain', Duggan wrote. 'Michael deserved the accolades he received.' Arthur Duggan to GKD, personal communication, 12 August 2022.

[x] John Yeo, was the revered founder of RNSH's spinal unit, led it for three decades. He asked Cousins to study spinal cord injury pain because most of his patients suffered agonising pain.

[xi] Siddall, Taylor and Cousins divided spinal cord injury pain into musculoskeletal, internal organ, nerve and other types, and further subdivided nerve pain into two categories. Siddall, interview.

[xii] The RNSH research team developed a new rat model of nerve pain and, in one investigation, they showed that genetic changes occurred in cells above the level of the spinal cord injury. P. J. Siddall, C. L. Xu and M. J. Cousins, 'Allodynia Following Traumatic Spinal Cord Injury in the Rat', *NeuroReport* 6 (1995): 1241–44. See also P. J. Siddall et al., 'Increased FOS Expression in Dorsal Horn of Spinal Cord in Rats Displaying Allodynia Following Spinal Cord Injury', *Proceedings Australian Neuroscience Society* 7 (1996): 233.

In patients with spinal cord injuries, the team tested whether opioids and non-opioid drugs delivered via the intrathecal space relieved spinal cord injury nerve pain and found that if they combined morphine with the blood pressure-reducing medication clonidine, the heightened pain sensitivity was eased. From then on, they implanted tiny pumps into some of their patients, enabling the delivery of a continuous dose of morphine and clonidine into the spinal fluid. Philip Siddall et al., 'The Efficacy of Intrathecal Morphine and Clonidine in the Treatment of Pain after Spinal Cord Injury', *Anesthesia & Analgesia* 91, no. 6 (2000): 1493–98.

In another study, the team found that 150–600 mg each day of the anticonvulsant drug pregabalin relieved spinal cord injury nerve pain. It also improved sleep, anxiety and patient wellbeing. Philip Siddall et al., 'Pregabalin in Central Neuropathic Pain Associated with Spinal Cord Injury: A Placebo-Controlled Trial', *Neurology* 67 (2006): 1792–800.

The team also pursued spinal cord injury pain in the clinic, following up with patients from the emergency department through the rehabilitation phase to five years after injury. In this study, the researchers found eighty-one percent of the patients reported pain. Musculoskeletal pain was the most common type, with nearly sixty percent of patients describing their pain as severe or excruciating. Those with pain in internal organs, such as the heart, lungs, pancreas or intestines, were most likely to rate their pain as severe or excruciating. Philip Siddall et al., 'A Longitudinal Study of the Prevalence and Characteristics of Pain in the First Five Years Following Spinal Cord Injury', *Pain* 103 (2002): 249–57.

[xiii] Keith Cousins retired as chair of Australia's largest advertising agency, George Patterson, in 1984. One advertising industry chief, Terry Connaghan, said: 'Keith Cousins was a friend, counsellor and powerbroker to leading politicians of all persuasions, to the leading companies, and a very long list of businessmen.' 'Keith Cousins Is Inducted into *AdNews* Hall of Fame', *AdNews*, 27 November 2012, https://www.adnews.com.au/awards/advertising-hall-of-fame/keith-cousins.

[xiv] For more information on neuroplasticity and pain management see: M. H. Moskowitz and M. D. Golden, *Neuroplastic Transformation. Your Brain on Pain Workbook* (USA: Neuroplastic Partners, LLC, 2013).

[xv] For more information on the INPUT program at St Thomas Hospital, see: A. C. de C. Williams et al., 'Inpatient vs. Outpatient Pain Management: Results of a Randomised Controlled Trial', *Pain* 66, no. 1 (1 July 1996): 13–32.

[xvi] Cognitive-behavioural therapy includes stress management techniques, such as diaphragmatic breathing and muscle relaxation; identifying and modifying unhelpful thoughts about pain; pacing/gradual upgrading of physical activity to reduce pain flare-ups; increasing the consistency of activities; goal setting; and structuring of daily routines to maintain behavioural activation. It also includes addressing insomnia and effective communication strategies around pain-related difficulties. John Otis, *Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach* (New York: Oxford University Press, 2007); Beverly E. Thorn, *Cognitive Therapy for Chronic Pain: A Step-by-Step Guide* (Guilford Publications, 2017); Michael K. Nicholas and Steven Z. George, 'Psychologically Informed Interventions for Low Back Pain: An Update for Physical Therapists', *Physical Therapy* 91, no. 5 (2011): 769.

[xvii] Long COVID is defined as COVID symptoms lasting longer than 12 weeks. For research on the prevalence of long COVID see: Bette Liu et al., 'Whole of Population-Based Cohort Study of Recovery Time from COVID-19 in New South Wales Australia', *Lancet Regional Health—Western Pacific* 12 (24 June 2021): 1–6; Painaustralia, 'Managing Pain and Coronavirus, 2022, accessed 30 October 2022, https://www.painaustralia.org.au/getting-help/managing-pain-and-covid-19.

[xviii] Cousins insisted on 'getting the best deal for pain management'. He nurtured both sides of politics equally. During interviews, he would not specify his political leanings. However, his background, character and behaviour would suggest he favoured the conservative political parties.

[xviii] Jane Cousins, interview by GKD, 6 May 2020.

[xix] MJC, 'Phase Two—Opening Report Pain Management and Research Centre March 1997', Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 3. The new funds led to the centre's Phase Two development, made possible by the principal sponsorship of Manufacturers Mutual Insurance to the tune of $1.5 million each year for four years.

[xx] In the submission, the Centre for Anaesthesia and Pain Management (CAPMR) outlined that its research plan for the quinquennium from 1998 was to consolidate and extend the areas of inquiry that had already been developed by CAPMR. Its overarching goal was to integrate research, clinical and educational dimensions in pain assessment and treatment, and in anaesthesia and life support. The plan continued studies under three major themes: clinical research and development, basic and applied research, and educational research and evaluation. In its justification for the funding, the submission noted that 'clinical research derives from sound applied and basic research. Hence the integrated clinical program in acute, cancer and chronic non-cancer pain management; the substantial basic, applied and clinical research facilities; the unique multidisciplinary postgraduate diploma/Master of Science (Pain Management) open to all health professionals; and the unique educational facility for health care professionals.' Centre for Anaesthesia and Pain Management Research Submission, NHMRC Centres of Clinical Excellence in Hospital-Based Research, 1998, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 3.

[xxi] The RNSH pain centre was one of only eight 'Centres of Clinical Excellence in Hospital Based Research' among all medical research disciplines across Australia. James Strong, 'Nomination for Professor Michael J. Cousins, Council for the Order of Australia', MJC Private Collection.

[xxii] In the August 1998 *ANZCA Bulletin*, Cousins wrote:

> Fellows will be aware that ANZCA has been discussing the need to appropriately develop the role of ANZCA Fellows in the field of Pain Management. As an initial response to the obvious need for a professionally organised training program, the ANZCA Council approved the commencement of a 'Certificate in Pain Management' at the beginning of 1996.
>
> During discussions by the ANZCA Council in 1995, it was recognised the Certificate would be an interim measure and the Council in 1996 agreed to proceed with the development of a specialist qualification that at that time was referred to as a 'Pain Diploma'. The ANZCA Pain Management Committee was given responsibility for developing the Pain Diploma and it was agreed that this should be in keeping with the multidisciplinary nature of this field.
>
> Accordingly, the President of ANZCA wrote to the Presidents of medical specialties involved in Pain Management, namely: The Royal Australasian College of Physicians, the Royal Australasian College of Surgeons, The Royal Australian and New Zealand College of Psychiatrists, the Australasian Faculty of Rehabilitation Medicine of the Royal Australasian

College of Physicians. The Presidents of the foregoing Colleges/Faculty were invited to nominate representatives to join a 'Joint Advisory Committee on Pain Management' (JACPM), to be chaired by the Chairman of the ANZCA Pain Management Committee, Professor Michael Cousins, and also comprising five representatives drawn from the ANZCA Pain Management Committee and ANZCA Council. M. J. Cousins, 'Specialist Qualification in Pain Medicine', *ANZCA Bulletin* 7, no 3 (August 1998): 18.

[xxiii] No women were allowed to enter the club.

[xxiv] At the meeting:

> R. G. Walsh expressed some concern about the Council being asked to approve the principle of a new Faculty without prior warning or documentation for consideration beforehand. He cautioned against rushing into any decision at this stage. Following further brief discussion, M. J. Cousins moved, seconded by R. G. Walsh, that Council agree in principle to the formation of a Faculty of Pain Medicine within the College and requests the Executive to explore further its formation, in conjunction with the Pain Medicine Committee and the Joint Advisory Committee in Pain Medicine.
>
> Whilst supporting the principle, M. Martyn did not believe there was any need to rush the issue. J. M. Gibbs was supportive of the general direction but queried what would happen if any of the JACPM member Colleges are not keen to pursue the formation of a faculty. M. J. Cousins believed that the College runs a risk of losing the initiative if the current momentum is not maintained. He believed that Council's agreement in principle would give a form of encouragement to the other members of the JACPM which he believed were already supportive of the initiative.
>
> With regard to the possibility of a 'rival' qualification being developed by the Australian Pain Society, Professor Cousins was of the opinion that the provision of specialist qualifications should come under the aegis of the specialist Colleges and advised that he would be writing accordingly to the APS along these lines. The President put the motion which was carried. Minutes, ANZCA Council Meeting, 11–12 June 1998, Faculty of Pain Medicine, Series 16, ANZCA Archive, Melbourne.

[xxv] The board members included Suellen Walker; John Gibbs, Terry Little, Graham Rice, Milton Cohen, Pam Macintyre, Ben Marosszeky, David Jones, Leigh Atkinson, Michael Cousins, Roger Goucke and Margaret Benjamin. Geoffrey Kaye Museum of the Australian and New Zealand College of Anaesthetists, Pain and Progress. The Formation and Development of the Faculty of Pain Medicine, online exhibiton, accessed 14 August 2024, https://www.geoffreykayemuseum.org.au/faculty-of-pain-medicine-history/.

[xxvi] The guideline described the causes of acute pain and offered health professionals advice on how to assess and treat a myriad of painful conditions, such as burns and pain after surgery. It also provided guidance on acute pain management in children and patients with special needs, such as those from non–English speaking backgrounds. NHMRC, *Acute Pain Management: Scientific Evidence*, MJC Private Collection; Painaustralia, 'Michael Cousins. Nomination for Australian of the Year', August 2012, MJC Private Collection.

[xxvii] In March 2008, the NSW government conducted the Garling Inquiry into the state's health system following a series of high-profile medical mishaps in hospitals, including at RNSH. Cousins and several of his colleagues gave evidence. Cousins told the commissioner that he had watched staff morale and hospital standards erode in the past decade. 'RNS Department Head Says He's at His Wit's End', 14 March 2008. In the inquiry's final report, the commissioner, Peter Garling, wrote:

> During the course of this inquiry, I have identified one impediment to good, safe care which infects the whole public hospital system. I liken it to the Great Schism of 1054. It is the breakdown of good working relations between clinicians and management, which is detrimental to patients. It is alienating the most skilled in the medical workforce from service in the public system. If it continues, NSW will risk losing one of the crown jewels of its public hospital system: the engagement of the best and brightest from the professions who are able to provide world-class care in public hospitals free of charge to the patient.

Peter Garling, *Final Report of the Special Commission of Inquiry: Acute Care in NSW Public Hospitals*, 27 November 2008, https://www.dpc.nsw.gov.au/publications/special-commissions-of-inquiry/special-commission-of-inquiry-into-acute-care-services-in-new-south-wales-public-hospitals/.

[xxviii] From 1991 to 1993, the Appeal Board raised $2.7 million. From 1993 to 1996, $1.1 million was received in individual peer-reviewed research grants from the NHMRC, Joint Coal Board Research Trust, Northern Sydney Area Health Service, Commonwealth Department of Health, Workcover & Motor Accident Authority, ANZCA, Australian Society of Anaesthetists, Workcover and Sydney University. By 1997, the pain centre had won $3 million in grants and consultancies from international pharmaceutical and biotechnology companies. MJC, 'Fundraising Report: Donations Received and Application of Donations, Pain Management and Anaesthesia Research Centre, Royal North Shore Hospital', 1997, Centre for Anaesthesia and Pain Management Collection, Box 25.2, Folder 3.

Chapter Ten: The 2000s

[i] In the early 2000s, as president of the Association of Medical Professors of Australia, Cousins worked closely with the federal government. Between 2006 and 2009, he used his position as a councillor of the Australian Medical Council to influence health policy. Other roles that enabled him to interact with politicians and health bureaucrats and influence health policy included ANZCA vice-president (2003–04) and president (2004–06). Strong, 'Nomination for Professor Michael J. Cousins, Council for the Order of Australia'. MJC Private Collection.

[ii] *ICD-11* is the first version of the *International Classification of Diseases* to include chronic pain, and it is based on the classification on the recommendations of an IASP taskforce. IASP welcomed the inclusion of chronic pain in *ICD-11*, saying it is one way to 'ensure chronic pain receives greater attention as a global health priority. It is the hope of the [IASP] task force that the inclusion of chronic pain conditions in the *ICD-11* will further the recognition of chronic pain as a health problem in its own right and contribute to improved access to adequate pain treatment for persons with chronic pain worldwide.' Treede, Rief and Barke, 'Chronic Pain as a Symptom or a Disease'; Korwisi et al., 'Chronic Pain in the 11th Revision'.

[iii] Brenda Lau said she wanted to learn about the systems and policies determining whether health services such as pain clinics would continue to grow or wither and die. Lau's goal was to learn ways of influencing interdisciplinary pain management in her home country because she worried about the sustainability of pain clinics there. When she left Canada, few pain clinics existed, and the country lacked a nationally coordinated interdisciplinary pain management system. She wanted to return to her homeland and improve the outlook for Canadians suffering with chronic pain. Lau, interview.

[iv] Recognition of pain medicine as a specialty was a pivotal moment for the profession. After the federal government recognised the specialty, Medicare accepted item numbers for pain specialists. 'Before the change, if anaesthetists provided pain management services, the item numbers they used didn't cover the cost of the lengthy consultations', Goucke explained. 'So it disadvantaged them because the item numbers for anaesthetists were for procedures rather than the extended consultations required for pain management.' It was a significant milestone in the growing reputation of the Faculty of Pain Medicine. It also illustrated the federal government's acceptance of pain medicine as a medical specialty in its own right. Roger Goucke, interview by GKD, 23 October 2019.

[v] While all pain clinics in public hospitals were led by pain specialists, the composition of their interdisciplinary teams varied, and the services offered at each depended on the skills available. 'Most clinics had a psychologist and a physiotherapist but the programs at each differed widely', Brydon recalled. 'No other clinic offered an intensive three-week pain management program such as ADAPT. If they offered a structured program, its scope was limited because of capacity, skill or resource constraints.' At RNSH, new patients languished on the waiting list for two years, while at Royal Adelaide Hospital, the average wait was four years. It was a similar situation across Australia. Lesley Brydon, interview by GKD, 12 April 2019.

[vi] The staff Cousins recommended were an executive director ($100,000 for 12–18 months); a facilitator for the leaders' meeting ($5,000–$10,000 per meeting); an expert in strategic document structure ($5,000), a document drafter ($40,000); secretary to executive director ($40,000); strategic expert in health policy ($30,000); media liaison, political lobbyist ($40,000); video production, meeting organiser ($20,000); and website development ($10,000–$15,000). MJC, 'National Pain Summit Support Staff Recommendations', March 2009, MJC Private Collection.

Steering committee members stipulated that the strategy must address the lack of pain medicine specialists in Australia. Pain medicine had been a specialist area of medical practice for five years by then, yet Australia had only two hundred qualified pain specialists. Most worked in public hospitals because Medicare and private health insurance funding was not available for interdisciplinary pain services. National Pain Summit Initiative, *National Pain Strategy*, 4–6, MJC Private Collection.

[vii] National Pain Summit Initiative, *National Pain Strategy*, viii.

[viii] Cousins wanted to know whether people with chronic pain could access interdisciplinary pain centres in other countries, how governments funded pain clinics, and whether other countries had national approaches to pain management. He travelled to the United States, the United Kingdom and several European countries. National Pain Summit Initiative, *National Pain Strategy*, v.

[ix] Kieran Perkins, who represented those caring for a person living with chronic pain, spoke about Symantha Lui's years of travelling between hospitals, clinics, doctors and specialists. 'Like Helen Owens, Kieran acknowledged he and his wife received excellent care at some points in their journey, but that the care was completely fragmented.' Maiy Azize, 'Responding More Effectively to Chronic Pain', *Australian Policy Online* (17 March 2010), https://apo.org.au/node/20724.

In an interview with the *Canberra Times*, Perkins said: 'There's just the general disdain and offhanded way that people come to be treated because you can't see [pain], it's not an obvious affliction.' 'The more people tell you there's nothing wrong with you and the more people tell you that you just need to toughen up and get on with it, the more that deconstructs who you are as a human being.' Natasha Rudra, 'System "Failing" Chronic Pain Sufferers', *Canberra Times*, 12 March 2010.

[x] Cousins explained to Kerry O'Brien that doctors and health professionals didn't understand the fundamental difference between acute pain and chronic pain and that the two conditions require different treatment approaches:

> For chronic pain, a team of health professionals must assess the patient to identify the various components of the problem and then a program that includes self-management, exercise and counselling needs to start. But this is just not happening, except in a very, very few pain centres. The important point to make is a wide range of treatments exist now for chronic and cancer pain and what we need is for patients to get access to these treatments. But they are being discriminated against inadvertently because we don't have the resources to provide that access. It should be a human right for people to have access to this treatment.

MJC, interview by Kerry O'Brien, 'Painful Reality—Patients Let Down', The *7.30 Report,* Australian Broadcasting Corporation, 10 March 2010, https://www.youtube.com/watch?v=guiYQEJzIgw.

[xi] The steering committee included representatives of pain and palliative care organisations, human rights bodies from twelve countries, ethics consultants and individuals with publications on the topic.

Chapter Eleven: Pain Procures a Seat at the Top Table

[i] The Western Australian Government donated $50,000 and the pharmaceutical companies again contributed, providing unencumbered educational grants to ensure Painaustralia's voice and policy positions were independent. The advertising agency Morris and Partners worked with Brydon pro bono to develop the name and branding for the new organisation, and Corrs Chambers Westgarth developed the constitution, lodged a successful application for not-for-profit charity status and provided ongoing legal advice pro bono. Lesley Brydon, interview by GKD, 4 April 2019.

[ii] In his speech, Cousins thanked individual PMRI staff members, including Dr Charles Brooker, clinical director; Professor Michael Nicholas, director education and director ADAPT; Dr Paul Wrigley, director specialist training; Dr Gavin Patullo, head acute pain program, strongly supported by the head of anaesthesia Greg Knoblanche; Dr Newman Harris, senior psychiatrist; Dr Sally Preston, senior rheumatologist; Dr Chris Vaughan, acting director basic research program; Linda Critchley, co-ordinator clinical research; Hayedeh Jabbari, nurse unit manager; Lee Beeston, nurse unit manager ADAPT; Lois Tonkin, senior physio; and Professor Michael Nicholas, senior clinical psychologist. 'Last, but not least, my PA Helen Johnston.' MJC, 'Speech Notes', renaming event, Michael J. Cousins Centre for Pain Management, RNSH, 11 February 2014, MJC Private Collection.

[iii] A national survey conducted between July 2016 and February 2018 showed growth in the number of pain services in Australia during the previous eight years, though much of this expansion occurred in the private sector rather than in multidisciplinary pain services in public hospitals. Still, many people benefited from improved access to specialist services, and there was a fifteen percent increase in the number of new referrals that were able to be seen each year. Overall, median waiting times reduced from 103 to sixty days, though this was variable and, for some individuals, far exceeded the recommended six-month maximum wait, particularly for multidisciplinary programs. In a 2020 benchmarking study of 20,000 patients, the Electronic Persistent Pain Outcomes Collaboration reported an average waiting time of sixty-one days from referral to first appointment. Almost two-thirds of people were seen within three months of the service receiving the referral. S. Allingham, D. Shebeshi, H. Tardif, M. Bryce, K. Cameron, J. White, S. Damm and K. Eagar, *Electronic Persistent Pain Outcomes Collaboration Annual Data Report 2021*, Australian Health Services Research Institute, University of Wollongong (2022), https://documents.uow.edu.au/content/groups/public/@web/@chsd/documents/doc/uow274031.pdf.

Before the COVID-19 pandemic, there was mounting evidence of the value of providing multidisciplinary pain management programs via telehealth, especially in rural and remote areas. In a 28 November 2022 email to GKD, Michael Nicholas wrote:

> A lot has been happening over the last couple of years (and before) in relation to extending pain management options across the state using telehealth, including multicultural programs conducted by facilitators we have trained and delivered in the community language. We found that comparable outcomes could be achieved with the online group program (vs the in-person ADAPT program but note the patient populations were different (just over 50% workers comp in ADAPT vs <10% in my BPSM group).

Michael Nicholas to GKD, personal communication, 28 November 2022. See also: Michael Nicholas, 'Bridging the Gap: Applying Best Evidence Practice in Community Settings', New Zealand Pain Society Meeting, 2019, Michael Nicholas Private Collection.

During the height of the COVID-19 pandemic, telehealth was the only way most people could take part in a pain management program. The ADAPT program, which was delivered via telehealth, resulted in equal or improved benefits for participants and opened the program to people living in rural and remote areas or those who could not afford to travel to Sydney for three weeks to take part in the program. S. Overton et al., 'Descriptive Comparison of Initial Outcomes from Online vs In-person Delivery of an Interdisciplinary Pain Self-Management Group Program', unpublished report, 2022, Michael Nicholas Private Collection.