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NATIONAL PRESS CLUB ADDRESS [KELVIN KONG] [8 JUNE 2021]

MISHA SCHUBERT: Hello and welcome to the National Press Club of Australia for today's Westpac address. I'm Misha Schubert, one of the vice presidents of the club. I also happen to be the CEO of Science and Technology Australia. So today, as we begin properly, we acknowledge the country on which we gather and the traditional owners of the country and we particularly pay respect to elders and ancestors, the people who keep knowledge strong across a span of millennia that is awe inspiring.

Each year, the Australian Society for Medical Research confers its highest honour on a medical researcher who has made an outstanding contribution to their field, and this year's recipient is a proud Worimi man from Port Stephens, was the first indigenous Australian surgeon, and is working on the very frontline of ear, nose and throat services, including in remote Indigenous communities. To join the conversation online, and we do encourage you to do that, please use our handle @PressClubAUST, A-U-S-T, and the hashtag NPC. But first, would you welcome to the podium to formally confer the ASMR Medal for 2021, the Society's President, Dr Ryan Davis.

[Applause]

RYAN DAVIS: Thank you very much, Misha. Good afternoon and thank you all for joining us this afternoon for the presentation of the 2021 Australian Society for Medical Research Medallist. I'd like to acknowledge and pay respect to the traditional owners and custodians of country across Australia, particularly the Ngunnawal people on whose country we meet today.

The 2021 ASMR medallist, Professor Kelvin Kong, is clearly a man who has great passion in life – a passion that is all about outcomes that are at the heart of the ASMR's vision for a healthy, capable, integrated and equitable society empowered through opportunity, awareness and education. With appallingly high rates of poor ear health in Indigenous children in remote and even urban communities, Professor Kong's mission has been to reduce these rates and the risk of hearing loss, which in many instances is highly achievable and has remarkable and lasting outcomes for a child's ability to learn, engage, and achieve. His ultimate goal is for all Australian children, both Indigenous and non-Indigenous, to have the same chance of having healthy ears, no matter where they reside in Australia. As at present, poverty and social determinants of health and access to culturally appropriate health care essentially underlie being born into a situation where Indigenous children are set up to fail. Professor Kong has a passion for life, for family, for community, for making a difference, for giving back, and for restoring opportunity to those who would otherwise become just another statistic of poor ear health and outcomes that brings. As a high school student, he was told by careers adviser that a university education might not be for him, but growing up around health, helping out community and with fiercely strong family support, he graduated from UNSW Medical School in 1999, became Australia's first indigenous surgeon in 2007, is now a leading ENT surgeon, researcher, advocate and about as far Gamon (*) as one could be.

His work has earned him many accolades that he attributes to the teams he works with and the people who support him. More recently, he has been profiled in *The Lancet* as a trailblazer for Indigenous health in Australia, awarded the Menzies Medallion for Leadership in Aboriginal health service, delivery, advocacy and research, and was named the 2021 City of Newcastle Citizen of the Year. Over the 22 years since the first ASMR medal was awarded to Nobel Laureate Professor Peter Doherty, there's been a wide array of local and international medallists. We're extremely proud to welcome Professor Kong to that distinguished list, and we celebrate him as our first Indigenous medallist. In its 60th year of advocating for Australian health and medical research and researchers at a public, political and scientific level, to empower research for a healthy and equitable Australia, it is my absolute privilege and honour, on behalf of the Australian Society for Medical Research, to present the 2021 ASMR medal to Professor Kelvin Kong. Thank you.

[Applause]

MISHA SCHUBERT: Thank you so much, Ryan. And now, would you please welcome to the podium Professor Kelvin Kong?

[Applause]

KELVIN KONG: Thank you very much for the lovely introduction and the awarding of the medal. Distinguished guests, fellow researchers, friends, and certainly the beautiful Aboriginal and Torres Strait Islander people in the room today and also those listening abroad. It is really important to be here today, and I'm absolutely honoured to be able to address the Press Club today and talk about some of the work that I do, but also hopefully share some of the passion I have in this area. I want to also acknowledge Dr Ryan Davis, who has been so welcoming, supportive, and whose organisation has provided such an opportunity to talk about something that we believe so strongly about.

Hearing versus listening. To me, this award recognises so many strong aspects. It acknowledges that I'm right, that the ear is probably the most beautiful organ in the world. It acknowledges the struggle that we have amongst Aboriginal and Torres Strait Islander people in trying to conquer something that is so beautiful. And I think probably the most exciting part about being here today is that it’s an acknowledgement that the broader public and the general population actually have a belief in this, actually have a belief in the ear disease, and actually have a belief in Aboriginal and Torres Strait Islander health, and I think it's quite important. So I hope to share with you today and bring my world to your world and experience some of the things I experience. [Speaks in Indigenous language]. Hello in my language. I do want to pay my respects to the Ngunnawal people, the land who were on today, but also those who are listening to the different countries that you're listening from and that we all, despite being so diverse, a one united front in this fight for equity. My name is Kelvin. I'm from Worimi country and that's in beautiful Port Stephens. I acknowledge my local Member here who's been so supportive in the work that I do and essentially thank everyone for that pleasure as well. The hard thing is that, to be frankly honest, I don't think people realise how important this is and what an impact it has on every child in Australia and what impact it has on so many people. And hope that what I can do in this talk is talk about some of the passions of the ear, some of the impacts of poor hearing, but importantly contextualise that in an Aboriginal setting, because one of the frustrating questions I get all the time is why is it happening to our mob and no one else, and finally, what it means to me and how we can take this forward.

Starting with the ear, and those who don't know my passion for the ear starts a long time ago. It is the most beautiful structure. And when you get to operate on the ear and see what it is, it is really incredible that whatever it is that made us made it so interesting and beautiful. The shape of your ear on the outside determines what kind of frequencies go into your ear canal, across into your ear canal into your ear drum, to move this beautiful thing called ossicles, which are hearing bones, which converts this non-visible mechanical energy for the sound wave into an electrical energy that you can hear across into your cochlea and into your brain. And the most beautiful thing about this is just the majestic way it does that without even thinking about it – that you don’t have to think about what you're doing, that you just actually pick this frequency up. And what's so impressive about your brain is that you can recognise different voices or different sounds without even looking, without paying attention, which is why visually impaired people do so well when there's good hearing. That when your mother calls you, you know it's your mother straightaway before looking at the phone and hearing the voice, whether it's your kids, your cousins, whoever it is speaking to you. That frequency of sound is something you appreciate. The fact that you're going to change that sound, to change the way in which you've behave. We you sound in a lot of marketing tools, marketing ploys, to allow us to hear better, but also change a mood that we're in. And so when you're going to David Jones, you might hear *The Girl from Ipanema*, when you go into a shoe store with my children, you're listening to hardcore rap, and it really inspires you to get your wallet out and buy something.

[Laughter]

And that's the important part of this, majestic thing called sound, which is so eloquent the way it is. And again, I say this very carefully with my wife in the room, is that, when I'm in trouble and I know I'm in trouble, I'll come home, put some nice music on that she enjoys before I even start talking to her [indistinct] to do something.

[Laughter]

So I'm just starting to change that mood or the mood in the home. And so this kind of important part of that is really trying to understand how we can utilise that. And obviously, the surgical world, this beautiful thing called a cochlear implant can work so well, which I won't talk too much about today. But, in saying that, the technology was researched in Australia, designed in Australia by the team in Melbourne. And the beautiful thing about the implant is that we, in Australia, led the world in universal newborn hearing. So that when a child is born in Australia, we can have a hearing test, test what the hearing is like, correct that hearing test, put an implant in, and make sure they're on their way. But why is it so important? It means that a child born in Australia with hearing loss will not suffer the disadvantages of having hearing loss in their life. If you do that before the age of two years or 18 months' years of age, you know that child will actually develop in a normal way in speech, language development, and most importantly, educational opportunity. The important part about that education opportunity is that they're going to be part of our fabric of society and become normalised in what we see. And it's really exciting because recently one of the implants I did was a child who was bilaterally, or deaf in both ears, with implants and is now Dux of Year 6. Not doing well, Dux of Year 6. That's a huge impact and that's changed their trajectory for the rest of their life.

So how does that impact us in the Australian world in terms of Aboriginal and Torres Strait Islander people? Well, it's a different story altogether. Rather than talking about these magnificent technologies and research and design that we have in our country, we're talking about depravity of disease and isolation, and really raw impacts of access to health care. So if I tell you about a boy called Jimmy, who I met at a clinic at a very early age, six years of age, you can just picture him there with his siblings running amok, not leaving anything alone, tossing things around, misbehaving, swearing, cheeky smile, discharge out of his ears, discharge of his nose. You just know this kind of kid is going to be a hard kid to look after, but there’s a lot of fun. And so for us, the medical question or the surgical question is how do we correct this to make his ears stop discharging and hearing? But I contest you, that's the wrong research question. The research question is why is this happening to a six-year-old kid in an urban society where we have equal access to health care and it's not happening to anyone else? What is it we're going to do to restore that hearing so we can restore that education outcome? What factors do we need to put in in both those structural and systemic changes to make sure this doesn't happen again? And when you see this time and time and time again, you realise that frustration that you're expecting, because as a surgeon, I just want to correct that hole in the ear. When in actual fact, the question is how do we change our society? How do we change our health care system to make sure this kid doesn't fall through the cracks? And even if you dislike Aboriginal health, as a taxpayer you should be offended at the money that we put into the back end of this rather than the front end to correct this and make sure this kid has a good life.

And so outside of the clinic he was different. He was a naughty kid in the classroom, he was put up the back of the classroom. He was dismissed from class quite a lot. He had a lot of absenteeism from school. The parents had a lot of marital issues because they were having time off work all the time arguing over this. When in actual fact, this kid should have been brought in, put up the front of the classroom, realised there was a hearing issue and addressed it very quickly. And I think that's what's really hard, because the hearing he had was not conducive to learning. He would be poorly, but he was not listening. He was not actually taking in the surroundings and getting the education he required. So the factors that led to his ear disease was not about just a perforation or an infection, it was about the whole journey and getting to the age of six with ear disease which has been there for five years.

A second child I saw hid the reality of hearing loss and that access and the point of care. The bigger issue was how this has been recycled. And I was one night late at work and I was walking out through the emergency department after seeing another one. And I saw in the corner of my eye, this mother was quite distraught, getting quite upset that no one would see her 10-year-old child. Inquisitive and obviously feeling for her, I dislike people waiting for such long periods, so I snuck back in, got the files and started seeing them. And what was hard was when you actually realise the story. Their story was about the ear pain in one ear and the discharge in the other, and how she got to be in this place and the care that she had. That she was a single mother working two jobs, that couldn’t get to a local doctor. There was no bulk billing practises nearby. She couldn't leave during the day, so she finished her day at work before she’d start her night shift job, before the aunties come over to look after, bath the kids, put them in pyjamas, trudge them up to the emergency department, had been waiting there for four hours. And when she rocked up to the emergency room, was told this is not an emergency, it's an ear problem, go see a GP. So I immediately judged on that aspect and had said, no, I can't do that. I'll just wait here, kids have been bathed, I'm happy. But more distraught than that was underseeing the system that was in place. Here she was seeking help in a very desperate situation for her children that she loved and yet she was being judged on the way she was caring for the children, making right up in the emergency department. But also how the access impacted on her general well-being, her mental health. The fact that she was a single mother and the stress of that with the children, the fact the children were spending a night in emergency because that's where they had to wait to get the help, that the social ramifications for the whole family of this were just huge. And yet all we're talking about is an ear infection. Enough of us would probably deal with this in this room because we know the help we get and we know the kind of access that we have. So the broader picture of that is really about the simple disease process that the access to care and a structural process that we need to put in there.

So hopefully you’ve had dinner because now I’m going to talk about the gross part of it. And the important part of that is in my third story, which is another person who I’ve looked after and all the stories are interwoven, they're not related at all but it kind of paints a picture that I see. And this is a man in his 40s who presented with what he described as [indistinct] in his ears, ringing in his ears. And he had all this discharge and pus coming out of his ears and he just wanted to be seen. He was homeless, unemployed or in fact, unemployable, no education, in and out of the jail system, incarceration, social disharmony, breakdown from his own family, identity issues. And he used to get a hose in his ear, just to squirt all this gunk out of his ears because it was driving him crazy. And when you looked in his ears, you saw maggots. This is in my hometown, Worimi country, where we have the best hospitals in the world. We have the best living conditions in the world. And there is this real dichotomy of who's being looked after and who's not. And it broke my heart when you go look at the medical file of this, because you can go right back to the very early stages of it. From a very early age of 10 years of age, there’s a presentation with ear disease. Six months later, ear disease. Another one, ear disease, chesty cold, snotty nose, ear disease. And all the referrals are going back [indistinct] get it all sorted out. And it never happened, well it certainly never happened in the medical notes. And so from the hearing access, there was no education. With no education there was no employment. You can only imagine what he went through when you looked at that six-year-old kid I talked about before with the kind of disharmony they had going through that process, that this continues to cycle on and recycle because his own children who he’s disengaged with now, have similar kind of ear troubles. And here he was, sitting in emergency, waited eight hours to see someone because of something that was so simple. A proud man who's been broken down by the system that let him down. How is that different? I look after all patients. My non-indigenous patients get the access to health care. If you live in the right postcode, you get the right care. If you make the right noise, you get the right care. Yet there is cracks in our health care system that allow our most vulnerable to sneak through. And the problem with that is that these are the social consequences that we deal with. And so when we talk about ear disease, we're talking about a bigger picture of disharmony.

How does that translate in today's society with 30 per cent, just under 30 per cent, of our incarcerated are Aboriginal and Torres Strait Islander people, yet we make up only three to four per cent of the population. 30 percent, that's huge. What's staggering about that is that of that 30 per cent, the majority of those have significant hearing loss and significant disease. Our juvenile justice system, only until recently in the Northern Territory was all Aboriginal people, all of them had hearing loss. So they're in the incarcerated area, they're getting told to do things, they're not hearing stuff. They're being yelled at to get to do things and they're still not hearing. So if they're not hearing, they get yelled at more and that's when all the disciplinary action happens. That’s how it cycles back into this deprivation, but also this constant thing of being yelled at just to be able to hear. Such a simple thing. And I go back time and time again to the place of what if I met this kid at two? Could I have made a difference? And I categorically say yes because with our beautiful technology of cochlear implants, I change a kid's life every time we do an implant. So why can't we change that? What can we do to change that structurally? I think a lot of that comes back down to where the research is for us, because for me, the research is actually asking the right question. The right question is what are we trying to achieve? We're trying to achieve equity in our country so that every child born in this country, no matter who you are, no matter where you are, has equal access to health care, has equal access to education and has equal access to having a dream, a simple dream of becoming whatever they want to be.

And so how does that fit in the landscape of Australia? And it pains me to talk more about this kind of stuff because it's a reality, but I don’t think we realise what that context is. And it never surprises me, the deprivations that were forfeit for my mother, for my grandmother, for my grandfather, for my family. That they endured things where they weren't allowed to go to pools or swim, that they weren't allowed to go to the library, that they weren't allowed to go anywhere without having a permit, and that when my mum was young, my nan ran away so that she wouldn't be taken away from her family because she wanted this simple dream of having an Aboriginal family and having a family together you could grow up with. And it was lovely for us because what it meant was we had this harmony, but also this love that could not be broken. And so when you grow up in those kind of areas where going to movie theatres, you’re only let in after dark because they don’t want the savage people going to movie theatres. And what’s worse, you were sitting up the front because you weren’t allowed in the seats, so you had a sore neck by the time you get out of there, and I still listen to my aunties now, their voices in their head talking to me about laughing and how much fun it was when in actual fact, it was terrible.

[Laughter]

And so when they say that and they see that, it probably puts a real important perspective on the kind of access that they’re getting. So if that’s the way you’re treated in society in general, then fancy going to the hospital thinking you’re going to get helped. And the research landscape has been so against our people for so long that we want to do a project, I’m going to get a PhD, I’m going to research [indistinct] rather than, can I help you? How can we go about getting help?

So I say this all the time, if you’re doing a high degree to get a high degree and that’s why you’re doing it, you’re doing it for the wrong reasons. The reason we do research, the reason we do this kind of work, it’s going to make a better Australia for everyone. And what’s nice, we do that and make that an international perspective, then it’s wonderful for all of us. So, when you see these ear operations and the hearing and the restoration of those, and the stories you get with that, it just brings so much more joy and happiness to your face. Every day coming home and hearing that – and I’ve told this story many a time before, but I had this one kid who couldn’t hear, and the first thing they told me when they came back was, Dr Kong, did you know farts make noises?

[Laughter]

And it was a beautiful experience because all they wanted was this enjoyment of sound and they were dancing very uncoordinated but it was funny. But that simple thing that we talk about with a hearing test of being able to hear is far more important than that, and far more personal than that. That personal touch with interaction is probably highlighted in this COVID period. But we're alone and we're not hearing those kind of things. We miss out and probably highlight how important it is to be able to interact and do those simple things.

I was fortunate enough to be present many, many years ago at the 40th anniversary of the referendum where I first met Misha, and one of the fun things about that was the interaction with one man who's not with us anymore. Again, a sad plight of our closing gaps stats, that my grand- my children don't get to see their grandmother, how much fun that was. And a funny thing about the whole event was, you know, the event was fantastic, and it was really encouraging to see all the survivors and all the things they did. But the funniest part for our family was watching my Nan go through this thing called life. This is a lady who grew up in the bush, who took her children away so they wouldn't be taken away, come into a world where she didn't see. So she caught the plane down and I couldn't get on the plane with her because I was working. But I- there was a photographer on the broadsheet papers that was taking photos and following her. I think he was going to get clobbered her because she was so terrified of flying. But, you know, the simple thing is it was such a big day. And at the end of the day, we went back to the motel and, you know, do you want something, Nan? Let's get some room service. What? Someone's in the kitchen waiting for me to order something.

[Laughter]

And I just sit down there? Can we go and have a [indistinct]? And just that bizarre concept that we just take for granted in the simple things in life- in our general freedom, but also the simple things in this thing called humanity and being a human being amongst this beautiful nation, and I think that was really nice for her to see that. But the important part that Nan and Pop and my mum taught me was about education and education is our way out of this. And that was driven home to us. And my mother was a nurse. She was one of our early nurses in the country, did a lot of things and continues to do a lot of work in that area. My sisters also graduated from Sydney University and I aspired following in their footsteps. So this matriarchal passion of education, to change the way in which we're doing things. This was the important part that we had to do because of witnessing the hardships, experiencing what we saw in the social circumstances in the hospitals and how we could actually try and make a difference by partaking in this.

The barriers to health care we saw going through medical school was incredible. A simple thing, like a guy going to try and have ischaemic heart disease assessed, never showed up for any of his ECGs, never showed up for any of his treadmill tests. And the reason he didn’t, he was too embarrassed the only shoes he had were shoes he wore to church on Sunday, and he didn’t want to wreck them on the treadmill. And he was too proud to say that he didn’t want to run barefoot on the treadmill. And it really comes in home on this thing I go back to again about access and being equitable in there. So, again, going back to the research question, really being focussing around what we're trying to achieve and who we're trying to achieve this for. We need to see people that can be there. So that when we're talking about research and I implore you in your own institutions to reflect on how we're actually building that capacity, not about just on the research project and Aboriginal health, but how we actually engage in the community in a real manner. How we bring that journey along with them, how we inspire young kids to get involved in this research, and importantly, how we actually put them onto a pathway to better education, so they can actually lead the question.

And one of the sad things I've done in this kind of project, is that we're seeing all these amazing, young, talented people come through who are much smarter than me, who are doing better things than me. But it's a really nice reward to see the kind of work they're doing and the stages they're doing because we're pushing them through that capacity process and sometimes we forget how important that is. It's about a simple freedom, a simple freedom of being able to do what you want to do, but in an environment which you can actually make a control over and actually control your own destiny.

For me, a lot of my early heroes were not sports heroes, and that's probably a bit unusual for an Aboriginal man. I had many outdoor sporting heroes, but my two heroes, I’d still say to this day, Louis Peachey and Sandra Eades. The first graduates from the University of Newcastle. And I still remember this day, when I saw them speak thinking, wow, you can be a black fella and actually do something. That was really cool. And the important part of that is encourage us around us to really push harder, to do what you want to do. What everyone needs is some nurturing, what everyone needs is some understanding, what everyone needs is a pathway out of this.

What's exciting is that like so many other young, deadly people here, things are changing and medicine and a research field is evolving. And that evolution is increasingly exciting because of the rooms that we're addressing, the participation in this area, but also the questions I'm receiving now are no longer those simple questions. The questions we're seeing now is Kelvin, why’s a non-Aboriginal person need this research project, coming from a non-Indigenous person. Kelvin, how can we actually make that better? I'm running a workshop. I'm getting schooled by my non-Indigenous peers about making it more Aboriginal-friendly. And I think that's really cool. And that's changed the way in which we're doing things.

As a nation, I think we have this great momentum for equality and equity. And I'm grateful for those who want to share this journey. I hope I've tried to illustrate this journey and capture my story without blame, without sorrow, but rather the theme of knowledge and understanding, which is what research is about. We can't change the past, but we need the leadership to take us forward. We now have the ability to write the history and change those research projects to make a better outcome for all Australians.

I have the coolest job in the world. I go to work. I get in pyjamas, I listen to music and I help kids. And what's really nice for me is that allows me to do this in a way which is actually going to make a difference to the fabric of what we're talking about here. And it would be remiss of me not to mention all the researchers that have done this for me and helped me in this pathway, because anyone who thinks they're going to research alone is lying. It's a community of hundreds and even thousands of people. Communities, researchers, we all work together and I want to acknowledge everyone who's in our Ear Health for Life group because we actually work so well together. But most importantly, I want to thank my family who allow me to do the crazy things I do. I've been very fortunate to have a family which understands me, and I have a family that actually believes in our kind of passion that we have as well.

Education is our saviour, research is our weapon, and the Australian public is now our friend. Thank you.

[Applause]

MISHA SCHUBERT: Thank you, Kelvin. What a really inspiring speech, and I feel like you've taken us neatly through that narrative arc of the joy in your work and professional engagements and community engagements. But also some of the, you know, heartache with the big challenges that we've still got to wrestle with as a country. So I wanted to just start there before we invite some questions from our media panellists. How do you keep that balance in the sort of the joy and the heartache of some of the things that you've just described? And when you're feeling the heartache, how do you recalibrate to remind yourself about the importance of the work?

KELVIN KONG: I think I've always had a good empathy for- Oh, sorry, just let me rephrase that. I feel I've had a good empathy with understanding children and the plight they take. Having children of my own has taken it to a new level. And when I think about the misfortune and what they've unsuccessfully been able to do, that breaks my heart that we're not actually doing that. And so I think that drives that burn to actually want to change that. And the bit that rewards me is when you see the difference in their behaviours, in what they're doing. When parents come back and say: you've changed my child, they're talking, they're interacting, they're an angel now, is really, really exciting. But when you hear the stories they bring back, because all of the education [indistinct]… but the stories I get back are nothing about that. It's all the fun things about running amuck with their cousins, with their siblings [indistinct]… so the hard days(*) are always taken with a grain of salt, because the good days far outnumber that. And I think when I have some of those hard days, coming home to my children – and my children suffered ear disease, I'm happy to say that – and the change I see in them, I just think this is why we're doing it: because I want the best thing to happen for all our kids.

MISHA SCHUBERT: Yeah. You raised that issue about Indigenous detainees in the prison system and the huge proportion of people who've got quite chronic hearing loss or hearing challenges. It sort of takes us to that discussion that's been happening with evermore vigour over the last year about the Black Lives Matter movement and Indigenous deaths in custody. What are some of your(*) thoughts on how we see more progress on those issues?

KELVIN KONG: It's really hard and complex because it takes a lot more at the pipeline level to make sure it's done. The fact that we see deaths in custody from ear disease in 2021 is a blight on our nation and appalling. We need better ways of marking what's happening. We need better ways of interacting. We need better ways of picking up. And we don't have the data to actually bad that up. And so our research efforts have to be around picking it up early, finding out what constitutes(*) that, and actually working backwards to make sure that it happens. At the same time as our huge population which are incarcerated to make sure that hearing health is the number one priority in their care.

MISHA SCHUBERT: Do you think people who run prison systems or the state governments and jurisdictions who are in charge of the prison systems should actually be engaging in a proactive outreach programme with the ENT community to bring that expertise in?

KELVIN KONG: I think it's a combination of a whole heap of things, and I think the important part of that is the conversations have to happen, and we have to listen. And I think part of the journey I've been on with the ear disease journey is if you take five minutes to listen to the community and the problems, then you actually come to solutions. So we need to listen to the incarcerated. We need to listen to their families when they hear what's going on. So we can actually focus together. It takes a whole lot of us to actually change this. The governments absolutely have to be involved in this because they're the primary caretakers. But also, all of us need to be in there with our societies, with our college(*) [indistinct] with the medical efforts and the hospital system to make sure they're linked. Because they move around so much, which makes it hard. But also just to get some simple help might mean a whole lot of social change within the prison structure, which I have no idea about in, what cell you're in, who you're with, what's going on. And so a lot of them don't want the help because they don't want to actually upset their little niche market that they've got in their little environment there. And that plays a huge role. So understanding all these issues will make a big difference to the immediate role, but then playing more at the pipeline, the beginning of the process, will make a big difference in stopping these kids from going into incarceration.

MISHA SCHUBERT: The other really big issue, I think, that the nation and the medical research community are trying to navigate is obviously the vaccine rollout with COVID and particularly thinking carefully around the additional risks in Aboriginal and Torres Strait Islander communities around COVID to make sure that that rollout of the vaccines is done really, really well in communities. Wondering what your thoughts are on how that work is progressing and the degree to which it's informed by some of the best Indigenous health experts around the country.

KELVIN KONG: I think firstly it's important to recognise how much a difference are we've made across the world in our indigenous communities. And that's a testament to the Aboriginal leadership for many organisations here. And I think that's probably not highlighted enough or enough accolades going their way. The second thing is I think based on what you heard today, hopefully, there is a real distrust in the health system when everything's always being [indistinct]… down upon our people. And so a big part of that journey is a translational research to understand that it's not our problem that people aren't having any control over this or some of the hesitancy. It's our fault that we're not actually translating information to say, you know what, this is why we're doing it, and this is how we're doing it. And it's very important for us, too. I'm a very, very strong believer in vaccinations(*). I've had my vaccination. I was very proud to. And I'll do everything I can to turn every stone possible to make sure our mob's looked after, because it's going to make a big difference to us. So I think it's an important process we need to do and look at all the different factors in there. But understand that there are different factors that are playing a role in some of the hesitancy and understanding those to make sure that we can deal with them.

MISHA SCHUBERT: And just even you talking about the fact that you've been vaccinated, how important are visible public role models in nailing that piece of work, in landing that [indistinct]?

KELVIN KONG: I hope it's good. I'm not sure the answer to that. Because I was fortuitous in getting my vaccine because there was some hesitancy within our hospital. And so they called me and said, you want to get a vaccination? I ran down there. I was pushing people aside to get down. I think it's a really important thing for us to realise how important this is. And I think- a quote I heard last night, which I really like, is that we're not out of this until everyone's vaccinated. So if there’s a handful or a small portion of us that aren’t vaccinated, then all of our vulnerable are still at risk, and the risk is too high. And that's what we've got to get rid of, so make sure that we’re all done.

MISHA SCHUBERT: So what's your message to all Australians then about what this will potentially unlock if we do get to a really high level of vaccination?

KELVIN KONG: I come back to looking after each other and caring for each other. The high level of vaccination is imperative for us as a nation, but the high level of vaccination means we’ll get back to our normal international travel and all of the things that we want to do as well.

MISHA SCHUBERT: And how concerned have you been to see some of those cases that have come out of the hotel quarantine, and how quickly a circumstance can change thinking of all of those people in Victoria?

KELVIN KONG: It's frightening. I think the biggest problem we're going to have with this going forward is complacency. There is this complacency that we can get away but not worry too much. And you can see what's happened with some of those flare ups. It just comes so quickly. We're very lucky in Australia we haven't had those debates. And one of the early debates they had COVID first came down was quite frightening because we're talking about who we're going to incubate, who we’re going to save, who we’re not going to save. That’s the conversation we’re having at a hospital level. We don't want to even be near that conversation, because I can tell you right now that our mob was not first on the list to be saved, and that's probably the hardest thing to talk about.

MISHA SCHUBERT: Yeah. We're now going to go to a couple of questions from our media members. Simon Gross(*).

QUESTION: Simon Gross, Canberra IQ. Thanks for your talk. I want to invite you to drill down into causes and treatments. From what I understand, a kid, it gets to three years old. About 80, 90 per cent of them are going to get some kind of otitis media. So the fact that the prevalence is so high in Indigenous communities seems to me to be an immune system challenge. And I also understand that it can be caused by bacterial and viral infections. So there's a range of the medicines before it gets to something like you with the surgery, which has got to be the last resort. So how do you understand the causes, and what do you see as the- where's the cutting edge in treatments?

KELVIN KONG: Yeah, it's entering(*)- again, going back to the science perspective of this, it's entering in the premise of the question. I think sometimes they play out race medicine or race health because it's an easier narrative to answer in terms of is it the immune system [indistinct]… there's a bigger health campaign around public health measures, and I think our primary health care community are the most important part in the prevention of any(*) disease. As you correctly say, most kids get this disease around the age of three to four, and you're probably going to get 80, 85 per of the Australian community that endure this kind of disease process. In Aboriginal communities, we're seeing the colonisation or the bacteria build-up in the nose under 12 months of age. So it's happening relatively quickly, and it means that there is a persistent cause of ear disease. Now, most people that I see in the knowledges community are looked at very early, the intervention's early, antibiotics, treatment, washing hands, blowing noses. And so they get back on the course very quickly. The biggest issue I find in our mob is that the access to care is quite poor. So by the time I'm seeing them, if they're getting ear disease at 12 months of age, I'm not seeing them till five, six years of age, and that's just way too long. And it's scary, because by that time, the complications of perforation, infections, hearing loss, language development, speech problems are all set in. And so you're always playing catch up. So a lot of the research we're doing now is how do we pick up those kids in zero to three to make sure that happens? And what are those factors we're looking at? There's a whole lot of factors: overcrowding, [indistinct] health, passive smoking, nutrition. Some of these communities you go to where you want to buy- you know, you've got two or three kids. You can buy an apple for five bucks or you can buy five packets of chips for three bucks. You know, they're not going to go buy an apple for five bucks and share that around. So how do we actually get all these other factors in place? And I agree with you, and I [indistinct]… completely with you there. If they're coming to me, we've missed the boat, [indistinct]… why we've got to go back to how do we drill down those early factors of preventable disease processes.

QUESTION: Thank you.

MISHA SCHUBERT: Our next question's from Nic Stuart.

QUESTION: Thanks. Your speech was titled Listening and Hearing. Here in Canberra, we're more used to people shouting and yelling. So that might be something you want to think about next time. But given that one of the startling things that you were talking about was the way in which that child once treated properly for the disea- for his physiological problems, he flourished at school. Two-part question. Firstly, what do you think the percentage of problems that we ascribe to social reasons, for example, particularly with your mob, the- we say First Nations people, Aboriginal people are disadvantaged. So therefore, we assume that particular outcomes are expected. To what extent are they physiologically based? And secondly, to what extent do you think, particularly early healthcare, basic primary healthcare, would make a difference for the outcomes of not simply the Aboriginal or First Nations people, but also other disadvantaged groups in the community.

KELVIN KONG: Thank you very much for your question. And I think, even the way [indistinct] that question, the answer is quite easy in that there is zero degree of physiological evidence that show while we're getting all these problems. And that's the hard part. And primary healthcare is absolutely paramount. And you look at the COVID period. The COVID period, obviously, the infection rates [indistinct] just plummet simply by washing hands, wearing masks, blowing noses, huge difference. And one of the things that really struck me in the COVID period was that we've been trying on this for such a long period time. And for so long, [indistinct] gone too hard to do. We can't do this. We can't do that. And COVID happens and then suddenly all these things come in play. [Indistinct] And the other thing really showed me that we can actually prioritise things. We're having many conversations about who we should be prioritising and who we should be looking after. And those conversations are quite helpful, because it really understood where we are in the health system, but also how we're going to triage when we're having these kind of issues are going on. But the most interesting part of that was that fascination of coming back to how we can make a huge difference at the early end of the spectrum just by prevention. And we sort of talked about that. And you look at the countries that didn't do that, that didn't follow masks, didn't follow handwashing, and look at the COVID rates they had, huge amount. It’s an amazing lesson in trying to achieve that. And I think for the kids and what you're trying to do in trying to make that outcome there, is that too much of it is accepted. So when they go to a community and see that the kids have just got boxes of tissues there, they've got cotton balls there, they’ve got drops there, and [indistinct] go, and this is a part of it. They just got to get part of that through there. Now, if that happened in the private school in Canberra or Eastern suburbs of Sydney, and every kid walked in and said, take a tissue, clean your ears out before we start the class, put your hearing aid on, do you think that would happen? There would be an uproar about it. And so I think the way in which we treat this as a big problem as well, because we’ve actually got a jump up and down and say: this is not acceptable. This is not acceptable. The community I went to, of the 100 babies I saw, one child was normal, and that was the teacher’s kid; unacceptable. I think that's where we've got to get that message across there and that awareness. And I go back to an old adage that I was taught by professor friend of mine, and that is every kid, every opportunity, every ear. And that means no matter who you are, we need to make sure we're looking [indistinct] and making sure they're a priority. And the hard part of that is that is not about health. It is about education. It is about the social system. It's about pre-school. It is about home care. And the most- the bite that I get the most from these mothers of young children. They're the ones I think that are key to this, because they're the ones to get the message out. So mums and bubs programs should [indistinct] hearing, the teacher program [indistinct] hearing, preschools [indistinct] about hearing. That is not a job of the Health Department. But try and get a room with the Health Minister, Finance Minister, and Education Minister, it just doesn't happen, because you don’t talk across those different silos.

MISHA SCHUBERT: Our next question from Andrew Tillet

QUESTION: Andrew Tillet from The Financial Review and Director at the National Press Club. And also class of 2001, Newcastle University.

[Laughter]

I went into journalism and obviously didn't make a difference to people like you’re doing. But anyway, thanks very much for your speech, and congratulations on the award earlier. But I wanted to sort of ask, I guess, take a bit of a helicopter view of what the sort of the future of medical research is in this country. You know, the last sort of 12-18 months, we've lived through COVID, which has had wrought economic disruption, geopolitical tensions, social issues, isolation, cutting us off from the rest of the world- even being cut off internally from friends and family in Australia. But it all boils down to it was caused by a health crisis, effectively, essentially. Do you think as we sort of approach this sort of COVID post-recovery period, it is sort of, going to refocus government's attention around the importance of medical research? Are you having, from what you're talking to yourself or talking to colleagues, or approaching governments, do you think lawmakers are more amenable to arguments in favour of increased funding for medical research? Or do you think the worry may be that we go the other way as we sort of live in these sort of financially straitened times and the medical research sort of hits the fence?

KELVIN KONG: A multi-level question. The hard thing with the premise of the question is firstly that the outbreak was not a health issue. The outbreak was a management issue. The health authorities knew what to do. It just wasn't enacted upon. And the research showed that. So the first thing is that research could have shown a quick way out of this, it wasn’t listened to. The second thing then is that research is so much bigger than the COVID problem, and research is always about what we're trying to do to make the community better and how we address that. My fear is we're going the opposite way, because research dollars are plummeting, and the economy investment in research is looked upon in a negative way. And that negative is that you're thinking about research. And often, people are thinking about labs and trying to work out different minutia, when in actual fact research is a whole plethora of a whole different aspect of things, and that is making sure that we're getting outcomes, making sure we're getting capacity, making sure we're getting future researchers. My fear is in 10 years' time, we're not going to have a senior researcher, because everyone's doing the research now, there's no money being invested in it. They'll go elsewhere and go do other things. And so therefore, we're going to have these paucity of intellectual power within this space to make sure that we're getting the right thing done. My hope is that we put more money into research. My hope is that we see this and see the importance of it, and hope when we retrospectively look at some of the learnings of the trouble that we've had with COVID that we'll actually pick up and say: well, you know what, that actually showed that we could have done this and prevented these things. And that means that we need to do more of this to make sure this doesn't happen. So we never go to lockdown again. So we don't have to sit with the family for a whole week again in the one, with one bathroom. So that aside, I think it's quite important for us to make that. So as part of this, I hope this brings more awareness to it, is I'll champion as much as we can for governments, but also for the private sector to come on board to actually complement that funding and match the dollars to make sure we're doing it, but also hopefully from the talk end is doing it in a complementary way that we do research for Australians by Australians, which would benefit Australians. [Indistinct] as an international perspective too that'd be fantastic. We have amazing research in this country and some of the people I've worked with, I'm just in awe of because of what they can do. But without being funded or having the processes to actually do their research, we get left behind.

QUESTION: Do you think we don't value our research enough? I mean, you think about something like the vaccine, how we've brought it to market much quicker than any other sort of vaccine as has been done? It was because governments said this is important, and we're going to throw money and resources at doing it, and we use science to get our way out of this. I mean, that that's an example of where research has value. Do you think we just, as a society and as governments, just don't start value it enough?

KELVIN KONG: I don't think we understand it enough, probably. And I think that's where I have a lot of issues with the research [indistinct] that. Again, we have this negative connotation of research, because it has negative impacts in the way we're doing it. Rather, the important should be about how we can engage better and therefore respect and value this. And the research that we obviously have are just incredible. I think we need to highlight that more, definitely highlight it more.

QUESTION: Thank you.

MISHA SCHUBERT: Our next questions from Astrid Watts.

QUESTION: Thank you so much for your talk today. First of all, I have two questions. Is that okay, Mish?

[Laughter]

MISHA SCHUBERT: Maybe? If they’re tight. Yes.

QUESTION: So thank you so much for your talk today and congratulations on the award. My question, first question is, where do you see the future of restoring hearing heading?

KELVIN KONG: Restoring hearing?

QUESTION: Heading. Like, where do you see the future?

KELVIN KONG: It’s an exciting future. The world of hearing is just an incredible world. This apparatus that we’re learning more and more about is just phenomenal. And to be able to interact in this world and see the difference is quite exciting. The fact we're doing implantation now in earlier and earlier ages is really exciting for us. When I first started doing implantations, the conversations were very different about how we’re introducing noise pollution to these kids who have lived in a very quiet environment. And their parents have grown up in a very quiet, and why would they want to poison their kids? And I think a lot of that was about fear of losing them away from their world of the non-hearing world. And they’re quite interesting ethical questions to get into. But that aside, I go back to the same premise, and that is the premise of any kid in this country should be able to dream and do whatever they want to do. And hearing in this world, unfortunately, is one of those important parts that gives you a little advantage. So I think it's getting better and better and more exciting in what we do. And the fact we can do these things at an earlier age, but also do these things with confidence and with good outcomes is a testament to some of the medical science research that we’re doing wonderful.

QUESTION: Wonderful. So the second question, do you see any way in the future or now, for someone who is profoundly deaf but wasn't diagnosed with profound deafness until they were in their 30s, that doesn't involve a cochlear implant or the wearing of what can be an uncomfortable hearing aid?

KELVIN KONG: Yes, and no. I think- certainly, depending on the case, they're probably hard for an implant when they post-lingual anyway. But in saying that, there's always things in the horizon. And this is where the beautiful part of that dream is. I'm sure and I'd love that day where you'd be able to inject something or reverse some of those genes and change it. I think the challenge will be about the neuroplasticity and what they've learnt in the past. But there are things that are being engineered now which blow my mind when I see some of the early trials. I don't want to excite with some of the things I'm reading, because they're not very well scientifically proven. But this world is going to change. And the evolution, the rapidity of which we're learning these things is just so fast.

QUESTION: Wonderful. Thank you so much.

MISHA SCHUBERT: Kelvin, have you ever thought about going into politics?

KELVIN KONG: Never. [Laughs] I think it's funny question, because it has been asked before. And I think I can- if I were to be very polite, I can stir the pot more from outside than I can from within. And that's exciting for me.

MISHA SCHUBERT: That’s a good audition. And just before we get to another question from someone else, I thought it might be worth reflecting in the context of your story about your nan and the kinds of deprivations and hardships for her generation, and your parents. How does that history live on in people's health?

KELVIN KONG: The intergenerational trauma is huge. And I think for me, it’s obviously changing, because of the drive, the leadership from mine my nan and my mum. But it's still happening in today’s day. You know, the trauma I seen in some of these incarcerated people I look after, the trauma I see in kids still being taken away now, is horrific. And when you're always in the state of higher inertia, a high adrenaline, high anxiety, your whole immune system changes. And this is not about Aboriginal change, it's about people and change. So anyone you take, if you have a long history of trauma and a long history of continued trauma, your psyche changes, your mental changes, your immune system change. It leads to all these kind of health effects, which are being shown and shown again. And I think sometimes, and I appreciate that we are looking at it. And the other thing we don’t realise is that we think about this in, you know, the 1800s. This is not the 1800s, this is 2021. You know, there's still things that are happening now. IF I can share a recent experience in the hospital system, where walking into the hospital, I was told: the loading docks around the back. You can't come in this way in the COVID environment. And this is someone I didn't know who was just from the hospital [indistinct]. And it was confronting for me because of the bias that they showed in looking at me and how I was dressed, and it was a weekend, I was doing the ward rounds so it didn't matter too much. But the bias they showed in the trauma that reflected on me. Now I'm strong enough to actually absorb that and it doesn't worry me. But when mob come and they're going to emergency, or going to see a friend, and they're confronted with this on a daily basis, it really takes the wind out of you when you face it on a very regular basis, which it really takes away from energy, but also the frustration. And if you answer back in a confrontational way, you're seen as a troublemaker. If you don't actually raise an issue, then you're being complicit. You know, there's all these things. And I think where we need to get better at this is, again, coming back to understanding our bias, understanding that conscious, and also delivering it so people are aware so that we become this harmonious kind of society where we're not actually judging people. It doesn't matter who you are, if you come to hospital, how can I help you? Simple question. Doesn't hurt anyone.

QUESTION: I reckon you're a bit too nice and a bit too evidence base to get into politics.

[Laughter]

QUESTION: Just going back to your one of your previous answers, this isn't the first time we've had a hearing as an issue in this room. I remember, four or five years ago, there was a gentleman, I forget the organisation. And he talked signing, and he an offsider of who spoke to us, and we asked questions. The offsider signed to him, blah, blah, blah. And he resented cochlear implants. There is an activist- well, they wouldn't call themselves hearing impaired, but there is an activist section of the deaf community who resents the idea that it's a disability. I wondered what's your view on that and your understanding of that, that mentality?

KELVIN KONG: That's very powerful. And I remember the first conversation I had with parents on that. And they were very active in that space and didn't want to poison their child's life with noise. And they've never had [indistinct] voice. They've always signed. I think it's wonderful. I think that's an important thing about choice, and that choice is about understanding that process. But also, I would hope they think that they would be able to understand that if they talking about themselves, that's a different ballgame than talking about a child or something they bring into this world. If they've endured some of the disadvantage and if they've endured some of their hardships that has taken with being hearing impaired, then I would hope that would reflect on some of the conversation. Part of that, when I talk about a cochlear implant with my patients, I try and insist that they learn signing as well, because it's really important to engage. And I think the conversation is not so much about whether or not we should be giving hearing, but it's about how do you engage with their child and them that they're not going to lose their child by them getting hearing, that they're going to still have that engagement with them. And I think that's the biggest fear is about the loss, and part of that loss and that grieving is that if my child becomes someone who can hear and talk, I'm going to lose them. And I’m not going to be [indistinct]…

QUESTION: [Interrupts] So you're talking about parents who are both deaf, aren’t you, [indistinct] there?

KELVIN KONG: Yeah.

QUESTION: So that's the main the main kind of sector.

KELVIN KONG: I may not have had access to the kind of implantation at their age. And so now they've got this dilemma of my child's got a hearing loss. We’re both deaf, we’re signing, why would you want to poison my child with this? And I think when I spoke with the parents about that, the conversations mean more about their loss and fear of losing their child to this hearing world. And I grapple with it, because I actually understand the pain they would feel in doing that. But also see the differences in the hearing world putting into there- I would certainly never impose one or the other onto them, because I think it's completely their choice. But I think it's important to have that conversation and try and untangle some of that work. And I'm not a psychologist or psychiatrist, so I probably couldn't give you a fair answer there.

MISHA SCHUBERT: Another question from Nick Stuart.

QUESTION: Interesting to open the paper this morning, see that brain surgeons and anaesthetists are two of the best remunerated professions in Australia. Disappointing, of course, to see that journalists and medical researchers were not up in the top level. What is it- do we need to boost money to individual researchers, particular programs of research, or more widely, just throw more money at the issue in order to hope that gradually the funding comes down and we get the breakthrough at the end?

KELVIN KONG: My understanding of research funding is probably not as good as a lot of people in this room. But I will say that I think the problem is the funding models are not adequate. Research is often based on cycles. And so you apply for a grant and you work through that grant process, and say: we’re [indistinct] towards that grant process, you're spending all this energy and time running your next grant to do that. Now, the grants are- where’s the NHMRC table. Alan. I’m a bit cheeky with Alan, because I know Alan. The grant process is always around December and then all the interviews early in the year. So research is never enjoy Christmas break. And so they're always miserable.

[Laughter]

I think that keeps us in place to make sure that we're not looking for the kind of remuneration we’re after. But also part of that is then- the funding of that is very specific and very tied to certain things. And I think there needs to be a broader kind of understanding of what research should encompass. The research teams that are involved. And again, I come back to the capacity of making sure that we bring in the people involved in the research into the project and actually make sure there's pathways for them as well. And I think that would change the way in which we're doing the research rather than reacting on one particular thing. But in saying that, there's a role for all these different areas. So we should be having small pockets for [indistinct] programs, but we should be looking at big broader programmes and longer funding programs that are dependent so much on quick cycles. But it's a huge topic to talk about.

MISHA SCHUBERT: Okay. Audition for another Press Club address. Ladies and gentlemen, would you please join me in thanking Professor Kelvin Kong.

[Applause]

We always like to leave our guest speakers with a little something. This is a membership of the National Press Club, so you're very welcome back any time when you're here in Canberra. And we'd love to have our speakers back to engage with the club always. Thank you so much again for today.

KELVIN KONG: Thank you, very kindly. Thank you.

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