PRIMARY INDUSTRIES AND RESOURCES COMMITTEE

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Mr SA Bennett MP—Chair
Mr NJ Dalton MP
Mr RI Katter MP
Mr GR Kelly MP
Mr JR Martin MP—Acting Chair
Mr LP Power MP

Staff present:
Ms L Manderson—Committee Secretary
Mr R Pelenyi—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE QUEENSLAND INSTITUTE OF MEDICAL RESEARCH BILL 2025

TRANSCRIPT OF PROCEEDINGS

Wednesday, 11 June 2025

Brisbane

WEDNESDAY, 11 JUNE 2025

The committee met at 11.18 am.

ACTING CHAIR: Good morning. I declare open this public hearing. My name is James Martin. I am the member for Stretton and deputy chair of the committee. The chair of the committee, Stephen Bennett, the member for Burnett, will join us shortly. The other members of the committee here with me today are: Nigel Dalton MP, member for Mackay; Robbie Katter MP, member for Traeger; Glen Kelly MP, member for Mirani; and Linus Power MP, member for Logan, substituting for Tom Smith MP. The purpose of this hearing is to assist the committee with its examination of the Queensland Institute of Medical Research Bill 2025. The bill was referred to this committee for detailed consideration and report. I would like to begin by thanking all witnesses for making themselves and their teams available today.

This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the hearing at the discretion of the committee.

I remind committee members that officers are here to provide factual or technical information. Any questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of the House. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. Please turn your mobile phones off or to silent mode. I will now hand over to the chair.

CHAPMAN, Mrs Fiona, General Counsel, Queensland Institute of Medical Research

ENGWERDA, Professor Christian, Program Director, Infection and Inflammation, Queensland Institute of Medical Research

MILLER, Ms Heather, Senior Legal Counsel, Queensland Institute of Medical Research

SHARMA, Professor Arun, Chair of the Council, Queensland Institute of Medical Research

CHAIR: Welcome. I invite you to introduce your team and make an opening statement, after which time the committee will have some questions for you.

Prof. Sharma: I am Arun Sharma, the chair of QIMR Berghofer Medical Research Institute. I will introduce my colleagues. Professor Christian Engwerda is a program director in the institute and represents the scientific work that the institute continues to do every day. Also with me are Fiona Chapman, general counsel, and Heather Miller, senior legal counsel. I am also supported by our head of engagement, media and government relations.

Thank you for the opportunity to appear before you today on behalf of the Queensland Institute of Medical Research. QIMR Berghofer has a proud 80-year history as one of Australia's leading medical research institutes. Today we have 1,000 researchers, scientists, PhD students and visitors working on breakthroughs every day. This proud history goes back 80 years, and it has made some major contributions in alignment with its purpose, which is to improve the health of Queenslanders. In doing so, it has come up with breakthroughs that have improved the health of not only Queenslanders but also Australians and the entire humanity.

Just to give you a few examples, in 1963 it discovered the Ross River virus. When I first came to Australia in 1991, I kept hearing about the Slip, Slop, Slap campaign. It was the research and the public health policy guidelines that came from the QIMR Berghofer Medical Research Institute that led to that campaign. During COVID, it continued to provide advice to the Queensland government and also do work that was very important. Today it has immense capability in immunotherapy, which

is a major area of medical research. We are saving lives under the special access scheme. We are creating therapies for which people have to go overseas and a single injection can cost somewhere in the vicinity of half a million dollars. We are doing it here. We are trying to scale this up. Every day QIMR Berghofer is trying to ensure that the research outcomes are not just something that we publish but are translated into health outcomes.

We welcome the focus on strengthening the governance objectives, enhancing accountability and transparency, but at the same time allowing the institute to have the agility to compete and collaborate with the best medical research institutes on the planet and, of course, in Australia.

Importantly, we also recognise the bill's focus on the commercialisation of medical research. Commercialisation of medical research, first and foremost, is important because many of the discoveries we come up with need to be commercialised, because they often require significant investment in clinical trials before patients can see the benefit. If we just publish a paper and let others do it, we are not capturing the value for Queensland. We are very grateful that the bill includes the commercialisation of research as one of the purposes of the institute. This is basically what we have been doing, but it will reflect the reality.

Similarly, we support the proposed reforms to the appointment of council members, the director and the CEO. Currently it has to go to the Governor in Council, but we believe the agility required to address these things via the Minister for Health strikes an appropriate balance between governance and agility. We are competing in a global environment. If we have to appoint a director, they may come from overseas and it may involve visa processes. These are lengthy processes. In the current geopolitical context, Queensland's and Australia's quality of life and our medical research capability allow us to attract talent, and we need that agility.

Many of these things are already being practised. We have adopted measures—for example, delegating to the CEO and the CEO delegating to other managers in the institute. The right thing is being practised, but the act will address it and formalise it. It is very timely. We commend the committee for undertaking a review so that we can operate with an act that is fit for purpose and sets the stage for the next 80 years of QIMR Berghofer.

CHAIR: Thank you very much for that overview. I will hand to the member for Stretton for his first question.

Mr MARTIN: Thank you, Professor. My question is about commercialisation. You mentioned in your opening statement that part of what the bill is doing is prioritising commercialisation. Could that affect the type of research the institute does? Is there a danger that it becomes focused on financial return instead of public good? Could it effectively lead you down one path, because you might get a return, instead of another?

Prof. Sharma: That is a very good question. It is not commercialisation for the sake of commercialisation. We determine the nature of research that we undertake which is aligned with the health needs of Queenslanders. Within that research, when we come up with a discovery, to ensure it has the maximum impact we undertake commercialisation as a process. Sometimes the research—like the Slip, Slop, Slap campaign—was a public policy guideline, so there is no commercialisation there, but the foundation of the research, which was peer reviewed globally, allowed the evidence base to be created so that public health guidelines can be improved, and that impacts the health of Queenslanders.

The primary directive of the institute is to undertake health and medical research that is aligned with better health outcomes for Queenslanders, but, within that, commercialisation is a necessary step towards ensuring that research sees the light of day. It allows us to get revenue. To give you context, we get around $19 million in operational funding from the Queensland government. We translate that into almost $120 million in research enterprise by applying for funding from NHMRC grants, the Medical Research Future Fund and other granting agencies. We have been supported in philanthropic terms by the community. I do acknowledge Clive Berghofer, who was made an Officer of the Order of Australia. We are very proud of what he has done, not just for us but also for the broader Queensland ecosystem. We also undertake many other commercial operations—for example, providing biotech companies with space so they can benefit from our medical research equipment infrastructure.

It is a constant struggle to find money to attract the world's top scientists and give them an environment to work. The commercial revenue also helps in getting a better revenue source for the institute. At the same time, we follow best practice—nationally and internationally—in rewarding the scientists when they undertake commercial research that leads to commercial outcomes.

You can rest assured: the council is very much aligned in ensuring that we decide what is the best research for the health of Queenslanders. Within that research, if commercialisation is the best mechanism by which the results can be seen in the Queensland health system in the long term then that is what we will do. The act allows us to do what we actually have been trying to do.

Mr DALTON: Professor, could you outline some of the research that excites the QIMR at the moment? Of the research that you are undertaking, what excites you? What is on the cusp of something really wonderful?

Prof. Sharma: I will say a few things and then pass to my colleague who is in the trenches working with the scientists. QIMR Berghofer has one of the finest research programs in cancer anywhere in the world. We can hold our heads high. We are at the forefront in immunotherapies and cell therapies. As I mentioned, for the past 20 years we have been undertaking cell therapy work where, under a special access scheme for patients who are immunocompromised, we are able to save their lives.

We have an example of someone from Brisbane for whom there was no choice: the only way with myeloma was to become part of a clinical trial in the US and that meant raising huge amounts of money. We understand that that did not work, maybe because the clinical trial was cancelled. Our scientist, who is a scientist at QIMR Berghofer and also a clinician in the Queensland health system, has CAR T-cell therapy, and she is under remission. We get examples and letters from all across Australia where we have manufactured this therapy to save lives. We are in the process of taking this 20-year capacity and experience into the next phase of building a manufacturing platform that can attract biotech companies from around the world so that we can manufacture the care in Queensland and then we can undertake clinical trials and they become life-saving therapies for people in Queensland and around the world. That is something I am very excited about. I will ask Christian to give you some more examples.

One area that I really want you to take note of is that most medical research institutes will work on cancer or chronic diseases. Very few medical research institutes have a very serious focus on mental health. We are proud to have one of the finest mental health research capabilities in the country. As we know, this is becoming a major issue, especially for people in regional Queensland and people who are working in the mining industry. We believe that this focus is very important and aligned. Our scientists have been involved in the discovery of some 300 genes that are linked to depression. We believe therapies will come. Christian, you are at the forefront of this.

Prof. Engwerda: There are two areas that I will mention that really excite me. One is in artificial intelligence machine learning and how we are applying that technology to diagnosis, in particular. You may be aware that one of the real bottlenecks in diagnosing someone with a type of tumour or those types of things is getting pathologists to read the slides. It is a real bottleneck. It takes time. We have a group that is working on generating algorithms that can look at those slides, which are taken as part of routine surgery. They can do several things. One of the things we are focusing on initially is trying to predict what sort of treatment would work best for that person. A lot of the time we use expensive treatments on cancer patients, for example, and it may work in 30 to 40 per cent of those patients. What we are working on is more accurate ways to predict whether a specific treatment will work for that particular person based on the tissue section that is taken. Of course, once you work out how to do that, that can be applied to many other different scenarios as well.

One of the things we are really focused on is remote health. Often, some of these biopsies can be taken in hospitals in regional areas and they have to be sent down to Brisbane. If you can do that digitally and then send that image to a centre, very quickly that can be assessed and a diagnosis, a prognosis, can be sent back to the treating physician and that patient can then get clarity about what their next steps are moving forward. That is one area that really excites us a lot.

Another area that we are working on, and one of the central themes of the program that I work in, is chronic disease and chronic inflammation in particular. Chronic inflammation underlies most of the diseases that really affect us. It is going to be the cause of a major health burden that the state of Queensland, all the states in Australia and many of the health systems in the world will have to deal with.

We have a group that works on what we call cardiac organoids. They get adult stem cells and from those adult stem cells they can produce these little mini hearts in dishes. That allows us to then challenge that tissue with various insults that might normally occur, whether that is something that is akin to chronic inflammation or a pathogen—a virus or a bacteria. Then we can work out what is happening to that tissue in that tissue culture but on scale. Then we can screen drugs that might prevent that from happening.

In fact, that is an example of something that happened during COVID. During COVID, we soon recognised that a major consequence of the disease was people developing chronic heart conditions after infection. We were able to quickly do the screen I just described and work out what sort of pathways were being affected in the heart tissue following what we call a cytokine storm, an acute inflammatory event because of the virus infection. Not only that, we were able to then identify drugs that could prevent that from happening. The clinical trials take a long time, but I think they have reached phase 2 clinical trials internationally. The drug we happened upon happened to be a Canadian drug from a Canadian company. We worked closely with them. They are in phase 2 trials at the moment for that drug.

I think that gives an example of how we can really respond very quickly to immediate threats but also look to addressing long-term challenges for the health system in the state. I can go on if you want.

Mr DALTON: That is wonderful news. Thank you for that very descriptive answer.

Mr POWER: I note that your site is obviously very close to the proposed Olympic infrastructure at Victoria Park. We anticipate tens of thousands of truck movements and also high explosives used to remove Brisbane tuff. Have you been consulted on the needs of the institute and are there any concerns about disrupting research and instrumentation and all those sorts of things through that construction period?

Prof. Sharma: No, we have not looked at it. We do know that construction happened next to QIMR Berghofer when the STARS building was built. It is all part of the process and we basically will deal with it. Our facilities team are well aware and if there are things that we need to get up then we will do that. We do not anticipate any issues.

Mr G KELLY: 'Slip, Slop, Slap': when I was going to high school, that ad came out and it went really well. Unfortunately for me, the damage was already done. Moving forward from that, have you noticed a decrease in BCCs in the younger generation? I will never forget that ad. It will be around forever.

Prof. Sharma: I am not an expert in the area, but obviously that campaign had major outcomes. Do you want to add something, Christian?

Prof. Engwerda: It certainly has made a difference, yes. The numbers are coming down in that younger generation of individuals coming through. Yes, it has made a huge difference.

Prof. Sharma: Some of the decrease at a population level is also a factor because we are getting a diverse population. With people like me—although I see a dermatologist every year, she does not find anything new in me, with dark skin, so that is also contributing. That campaign, from everything that I have heard, has contributed to numbers coming down.

Mr KATTER: I am coming from a pretty low base on this. I get curious when you talk about being commercially driven. Let us take cancer research—and this is a hypothetical, obviously. Say a commercial lens was prompting the organisation to put a lot of effort into an area that did not really fit the priorities of the general population or the government, which might say they want a lot more cancer research. Say you are a having a lot of wins and seeing benefits and breakthroughs in another area, so the commerciality might not align with the strategic objectives of the state or the people. Could you respond to that? I qualify again: I am coming from a low base here.

Prof. Sharma: You are absolutely right to ask that question. Cancer is a problem and every medical research institute is trying to do research into cancer. We have certain competitive advantages. We have been working in this area for 20 years, but that is not the sole driver.

We anticipated the mental health crisis that was beginning to happen. Unlike most other medical research institutes that are always chasing the things that everyone in America or Europe are doing, we said, no, we have to invest significantly in mental health research because it is important for the health of Queenslanders. We believe that, with fly-in fly-out operators separated from families for long periods, the corporate sector and the mining sector have picked on these issues. We can assure you as a council that we will undertake research when the foremost determiner is how it can improve the health of Queenslanders. Within that, if commercialisation is the mechanism by which these discoveries can reach the patients fastest then that is what we will support.

Prof. Engwerda: To add to that, we recognise that discoveries that lead to translation do not necessarily come from directed research. We maintain a broad base. We work on tropical infectious diseases, we work on cancer, we work on genetics—all of those disciplines. For example, I work on a disease called leishmaniasis, which is a problem in India. From our studies there we discovered a molecule that has huge implications for cancer research. By maintaining a broad base—by not saying

that we are going to work in this particular area to solve this problem but that we are maintaining a broad base—we just do not know what we are going to come up with. In fact, that leaves us in a really good and flexible position to be able to come up with solutions to problems as we generate more knowledge through the research that we do.

CHAIR: You have spoken about the enthusiasm and the exciting future of medical research in Queensland. Are there any barriers or predicaments that you would like to raise with the committee which you could see may be improved or changed to help your work?

Prof. Sharma: I think there is a lot of support for medical research, but it is a competitive field. Victoria has invested very significantly in medical research. New South Wales is also catching up. Queensland has made huge strides. The funding environment is constrained. We do believe that there is a case for additional investment in biomedical research that leads to biomedical manufacturing. The research not only improves the health of Queenslanders but also allows us to help create a life sciences manufacturing industry that creates advanced jobs in Queensland.

If you look at industry policy it can be the flavour of the month, but when you are talking about something like cell therapy, where a single injection can be half a million dollars in international markets, the labour cost becomes less of a question. That is the kind of advanced manufacturing, based on the research that our universities and our medical research institutes do, they can help create. More importantly, we want to make sure that this research is for the whole of Queensland, not just for people in South-East Queensland.

We believe QIMR is an institute for the whole of state, so we have a regional engagement program. In fact, we started the first in Toowoomba and the Surat Basin a month ago. We visited there and had a function and Chris spoke about the research that is happening. We plan to visit Townsville. We are looking at participating in a program with James Cook University. We send our scientific teams to different parts of the state to talk about it. We would like more patients from regional Queensland participating in our clinical trials. These are some of the most advanced clinical trials in the world, and this is how we spread and make a case.

Everyone is constrained. Every government is constrained in funding, but ensuring that the life sciences and medical research are pillars of the state is a competitive advantage. How can we align investment so that, in working with the federal government—because they have a lot of money to invest—we can attract more of that money to Queensland? That is a priority for all of us in Queensland. Victoria has done a better job than us. I think we should do that so that our research not only improves the lives of Queenslanders but also helps create an advanced economy.

Mr MARTIN: Professor, I wanted to ask if you are doing any research at the moment in relation to bowel cancer. It is Australia's second deadliest cancer and there have been quite a number of media reports highlighting that there has been an increase in younger people—people under 50—developing it. I think one in nine new cases is someone under the age of 50. I think I read that people born in the 1990s are now up to three times more likely to develop bowel cancer than those born in the 1950s.

Mr POWER: Of a similar age.

Mr MARTIN: Of a similar age. Is the institute looking into bowel cancer, and not just therapies or treatment? Is there something causing this? What is behind this?

Prof. Engwerda: We are working on that problem in several different areas. First of all, we work on the genetic basis of it, so we are looking at what genes might be driving that earlier susceptibility in individuals. That is from a population point of view. Recently, one of our faculty got an MRFF grant—a Medical Research Future Fund grant—to establish a system where we can actually take the bowel samples from patients, grow organoids in culture from those patients and test to see which drugs might work best in those individuals to treat those individuals. That is an active program that is going on at the moment.

Many of these cancers have a very common underlying basis. The research we do into inflammation in other cancers has applications to those sorts of diseases as well. We have the preclinical models that we can then use to test new treatments for bowel cancer as well. It is a very active area of research.

I should also point out that we have recently recruited a young woman from Oxford who will be joining us in August-September. This is exactly what she will work on. She will work closely with clinicians from the Royal Brisbane and Women's Hospital. They will provide the material for her to then try to understand both the basis of the disease and the individuals who are developing it. It is a very active area of research for the institute.

Mr POWER: Where you see an increase in a demographic, environmental factors could be a possible cause. Do you do any of that kind of demographic research to identify causes?

Prof. Engwerda: Absolutely. One of our big programs is population health. They are surveying the population routinely, asking various questions and looking for associations with lifestyle factors and other factors that might influence the disease to see if that relates to the increased incidence in particular groups—for example, young people being diagnosed with this disease. That will come out of those types of studies.

Mr DALTON: The Australian College of Nurse Practitioners have stated that they seek to address the limited public awareness of the contributions of nurse practitioners. Do you have any ideas how that would happen through your institute?

Prof. Sharma: One of the things we are trying to do at the institute is have better linkages between medical research and clinicians. We are working with Metro North to have clinicians who are employed jointly with QIMR Berghofer. One of the best things we can help clinicians do is to become research active. When they become research active—and I will come to the nurse practitioner question—their career takes off and that becomes a way to keep them in the state. Then they apply for more research grants that are clinically driven. Queensland needs to do more, and the institute is taking a lead with the universities in getting better linkages between clinicians.

The way we look at nurse practitioners is that they are also clinicians. In certain areas it will make sense for us to look at this program. I can tell you that in my past life at QUT we applied for a cooperative research centre in wound healing. This was a $100 million program over 10 years for wound healing. If you have a big diabetic ulcer and the bandage pressure is too tight or is too low, the wound healing takes longer. We had mathematicians modelling bandage pressure, polymer scientists designing the bandage and microbiologists looking at whether the wound was healing fast enough. The projects were led by nursing professors. It was said, 'You can come up with a fine solution, but if it does not operate in the Queensland Health practice then publish the paper and go back to the drawing board.'

There are cases where nursing professionals will have to be brought in at the point of service delivery for many of these therapies. I am not aware—and I am sure we can take this on notice—if we are doing a lot of things with nursing practitioners. With the clinical link that we are building with Queensland Health, we need to look at what is relevant for our research so far as whether a practice nurse can be engaged. I tried to answer your question. The intent is there.

Mr POWER: I really appreciate the work of the researchers. I have a brother and a sister-in-law who were both medical researchers. They are no longer because struggling with grants is a tough lifestyle. My question is about commercialisation. I have experienced a biological injection and know the benefit of that and the high cost to public health. Is there a temptation to invent novel solutions and novel drugs that really do not have the capacity to be part of a public health sector due to the very high costs? Is that something that core research focuses on—you are looking for something that will make a difference not only in the first-world, high-end medical context but also more broadly across the world because it actually makes the biggest impact on health? Is my question clear?

Prof. Sharma: I will answer and then I will ask Chris to contribute. I think this is precisely why we are taking cell therapies. It is unaffordable today. It is unaffordable for most Australians. They have to go overseas. The costs are prohibitive. Building a manufacturing capability here in Queensland and using automation and robotics to further decrease the cost so it comes within the reach of the health system is our primary focus.

You might ask if we are discovering things just because it is exciting and it might lead to commercialisation. No. It has to actually be better than anything that is available. That is required. We have to use technology to reduce costs. We have to start doing it here. We have to start attracting biotechs from around the world so they build an ecosystem. When we have the remote clinical trials happening, more Queenslanders will become part of those clinical trials. As Chris said, he is working on something in India which does not have any commercial benefit but the scientific input to other research is quite good. Do you want to address this?

Prof. Engwerda: We do think about cost all the time—the cost of these therapies. One really clear example of the way we have addressed that is in the cell therapies that Arun was just talking about. We generate antiviral cells, expand them in a tissue culture dish and then infuse them back into the patient. In the past that has been very labour intensive, time intensive and costly.

This has always had to be done on an individual basis. We would take your cells, expand them in a test tube and then put them back into you. The reason we had to do that was so the cells would not get rejected when they are put back into a different person. What we have found is that there are

families of the molecules that actually cause rejection, so we can divide patients into these groups based on those families of molecules. Now we can actually make these cellular products and put them in the freezer. When someone needs them, we can pull them out of the freezer, thaw them out and infuse them. This saves an enormous amount of cost and, more importantly, time for a lot of patients. That is one way we are thinking about those types of things.

We are also trying to look at more cost-effective ways of introducing these treatments. For example, we have heard a lot about the biologics for cancer treatment, these immune checkpoint blockades. It is very expensive. One of the most cost-effective preventives and treatments that we could administer is a vaccine. We have researchers now working on vaccines that can target cancer cells—either target the mutations that form in those cancer cells so we do not target other tissues or, more often, target some of the viruses that are associated with those cells. For example, a number of the viruses that we contract early in life are highly associated with the tumours that emerge later in life. For example, from the work of Ian Frazer on cervical cancer we know that the HPV virus is also associated with head and neck cancer. We are working on a vaccine against HPV that can be used to treat head and neck cancer as well. If that comes to fruition, that will be a much more cost-effective and probably more simple way of treating patients with these types of diseases. In summary, to answer your question, yes, we are really focused on producing solutions to the problem that are cost-effective and can be rolled out on a broad population base.

CHAIR: That is very exciting and very interesting. Thank you so much for your time today.

SEDGMAN, Mrs Rebecca, Policy Adviser, Australian College of Nurse Practitioners (via teleconference)

CHAIR: Welcome. I invite you to make an opening statement. After that the committee will have some questions for you. Thanks so much for making yourself available.

Mrs Sedgman: Thanks, Chair and committee members. I appear today on behalf of the Australian College of Nurse Practitioners. We are the national peak body representing nurse practitioners, who are autonomous, highly trained clinicians with advanced expertise in diagnosing and managing a wide range of health conditions. Nurse practitioners provide care across the life span, from maternity and neonatal through to aged and palliative care. We work across the breadth of Australia's health system including trauma, chronic disease, mental health and acute care. We also collaborate effectively with all health disciplines to ensure high-quality, coordinated care in and out of hospital settings.

As a college, we support the proposed amendments in the Queensland Institute of Medical Research Bill 2025, which aims to modernise and strengthen legislation to ensure it remains fit for purpose and reflects contemporary governance standards. As an organisation, we are committed to evidence-based practice and equity in health care. The college recognises the vital role of medical research in improving health outcomes for Queenslanders and for all Australians. These amendments are an important step to ensuring the institute is well equipped to meet and mandate in today's health landscape. Thanks again for the opportunity to contribute to this discussion.

CHAIR: Thank you very much. I hand to the member for Stretton to ask his first question.

Mr MARTIN: Thanks for appearing today. Do you think we need to invest more in including nurse practitioners in the field of medical research? Do we need to have a bigger focus on what nurses can do to assist us in medical research?

Mrs Sedgman: Absolutely. We are on the ground, at the forefront of medical care. I can speak for myself as a clinician currently involved in some research within an emergency department where we are trialling the effectiveness of methoxyflurane or Penthrane—the green whistle—against nitrous oxide sedation, nurse practitioner led, within our organisation. The trial allocates a patient to either the nitrous arm or the Penthrane arm. We have had some really great results in the preliminary results that have come through so far. The effectiveness is incredible. Research like this really helps clinicians around Australia when access to staffing and resources is poor. If we see that the Penthrane, for instance, is effective, there is a decreased need for an extra staff member to run the nitrous oxide. The other day I was able to reduce a dislocated shoulder with Penthrane, and that is incredible. One less clinician was required, which then increases resources in other areas of the department where they are required.

Trials like this which can have an on-flow effect—not just in Queensland but also around Australia—are really important. Because we have the ability to conduct such research and utilise not only medications but also other means of therapy, we can benefit the community. Absolutely, investment in a nurse practitioner and grants towards research will be very beneficial.

Mr DALTON: It is really tricky to understand everything you are saying, but are there any aspects of the bill that you would like to change? Could you articulate anything?

Mrs Sedgman: On our review of the bill initially we did not identify any areas that needed further review, no.

Mr G KELLY: Your submission is supportive of the changes in the bill. Do you think it provides the right balance between checks and balances and improving efficiency in the institute?

Mrs Sedgman: We see clinical governance as highly important. When you are overseeing trials that include medications that have not previously been tested in Australia on humans, that governance needs to be strong. We feel that the changes do reflect that. We feel that clinical governance oversight is well structured in the documents. We could not see any error or changes that we would like to suggest.

CHAIR: In your submission you make comments about eligibility criteria. Could you elaborate on that for the committee, please?

Mrs Sedgman: In which point was that?

CHAIR: In the makeup of the council.

Mrs Sedgman: I think it is eligibility in relation to having the skills required to make decisions within the council. We are talking about eligibility in terms of those who apply for those roles being fit for purpose and fit for the duty they have within the council.

CHAIR: The committee is satisfied with today's proceedings and we thank you very much for your submission. Thank you very much for attending today. We will conclude the proceedings. I would like to thank the Hansard reporters and the committee secretariat. A transcript of these proceedings will be made available on the committee's webpage in due course. I declare the public hearing closed.

The committee adjourned at 12.06 pm.