Is a clinician-researcher career viable in New Zealand?

Mark J Bolland, Andrew Grey

ABSTRACT

Recently the Health Research Council of New Zealand (HRC) announced the prioritisation of projects that enhanced the development of clinician-researchers. In this viewpoint article, we argue that a clinician-researcher career involving publicly funded, investigator-led clinical research with meaningful end points to inform clinical care is currently not sustainable in New Zealand.

Recently the Health Research Council of New Zealand (HRC) announced that they would prioritise 2026 Project Grant applications that enhanced the development of clinician-researchers.[1] This welcome change led us to ask whether a clinician-researcher career is currently viable in New Zealand. Our short answer is "No", but the longer, more nuanced version is not if you want to do continuous, consistent, adequately powered, publicly funded, investigator-led clinical research with meaningful end points that inform clinical care. Here we describe why we think such a clinician-researcher career is not feasible. We will focus on doctors in hospital medical practice, but the same arguments broadly apply to all clinicians whether they work in private practice or primary care, or whether they are other health professionals. We will take as our starting point a doctor who has completed their medical specialty training and undertaken and completed a PhD or similar academic degree. They would likely be 30–35 years old, and thus a sustained career as an independent researcher would last 30–35 years.

Clinical research backgrounds

Our views are informed by our experience. We have conducted clinical research continuously in Auckland alongside clinical roles of at least 0.5 FTE in endocrinology (and general medicine initially) for 25 years (AG, total 29 years) and 22 years (MB). Our salaries were funded throughout by an academic position at The University of Auckland (AG) and external funding solely (grants, fellowships, scholarships, MB). Collectively, we have applied for numerous grants, been the principal investigator (PI) on four HRC project grants, co-investigators on three HRC programme grants and been awarded a number of other national and local research grants. We have not been investigators in industry-funded trials. Collectively, we have more than 450 publications in peer-reviewed journals, including >20 randomised controlled trials, >20 systematic reviews or meta-analyses and >100 original clinical research articles. AG stepped away from leading clinical trials or being the PI for research that required specific funding in mid-career for many of the reasons discussed below. MB has now largely exhausted the possibilities for a fully funded research salary from external funding. We both were lucky at the outset to join an established, very successful research group, which gave us opportunities that a researcher looking to start a group or move into a new field would not have.

Clinical component for a clinician-researcher

When starting as a consultant, we think the minimum clinical job size is 0.5 FTE for most people to obtain sufficient experience in a timely fashion to bridge the gap between functioning as a senior registrar/fellow and a junior consultant. With accumulating clinical experience and expertise, it may be possible to eventually reduce this clinical component without compromising clinical care, although that might entail a narrowed focus. There are essentially two methods for obtaining a consultant position in the public health system: working directly for Health New Zealand – Te Whatu Ora or working as a university academic, whose clinical work is contracted to Health New Zealand – Te Whatu Ora.

Research time and salary funding

If working full-time (1.0 FTE) with 0.5 FTE clinical, this leaves at most 0.5 FTE for research. If in a university academic position, the remaining

0.5 FTE is usually split 40% teaching (0.2 FTE), 40% research (0.2 FTE) and 20% service (0.1 FTE), meaning there is 8 hours/week available for research. This job structure is fixed at The University at Auckland, but there may be more flexibility at other institutions.

An alternative approach is to fund the component of the salary for research using external funding obtained from commercial research or from grants and scholarships. The commercial research option is currently used regularly by many research groups: contract research is performed doing industry-funded studies and excess revenue that accrues can be used to fund research staff, equipment and investigator-led studies. The viability of this approach is highly variable among specialties, being heavily dependent on industry interest in the field, which can change rapidly. For example, our own speciality, osteoporosis, had great industry interest from the 1980s on with firstly preclinical research followed by the introduction into clinical practice of progressively more potent bisphosphonates from around 1995–2008. This was followed by similar programmes for selective oestrogen receptor modulators, strontium, PTH analogues and more recently RANKL and sclerostin inhibitors with the last major industry-sponsored phase three trial in 2017. There are currently no new osteoporosis agents on the horizon and industry activity has all but disappeared. While many research groups have successfully incorporated this commercial-funding option into their work, the ability to consistently fund a 0.5 FTE research salary over a career would likely be challenging for any group. At best, a fortunate alignment of career stage with industry investment is required. In addition, while undertaking industry-sponsored research can provide funds to support a research career, it also requires considerable time commitment, which impacts on the ability to conduct investigator-initiated research.

Funding a career from external grants and scholarships is even more challenging. The only large funder of grants and scholarships in New Zealand is the HRC, but there are only two major scholarships available for junior- to mid-career academic clinicians that fund salaries for up to 5 years: Clinical Practitioner Fellowships, for "*experienced clinicians to sustain and expand a programme of research*"[2] and Sir Charles Hercus Health Research Fellowships, for "*emerging scientists who have demonstrated outstanding potential to develop into highly skilled researchers.*"[3] Both are extremely competitive, with 16 Clinical Practitioner and 64 Sir Charles Hercus fellowships awarded over the last 10 years. There are few other opportunities from national cross-discipline funding bodies. Individual specialties and regional funders may provide some scholarships, but these too are limited in number, highly competitive, short-term and might target a specific career stage, usually early career.

For HRC project and programme grants, the situation is equally challenging. While such awards can be used to support clinical investigators' salaries, the reality is that the funder's budgetary constraints and institutional overhead costs severely the limit the extent of such support (see below). In addition, the success rate is <10% for applications. Table 1 shows details of projects and programmes awarded between 2015 and 2025 taken from the HRC research repository.[4] Over these 11 years, there were 413 projects and 52 programmes funded, approximately equally split between preclinical and clinical research. The majority of projects (73%) and programmes (93%) are led by professors or associate professors. Few individuals in this 11-year span had more than one project or programme awarded. Seventy-one percent of PIs for projects and 84% for programmes had only one project or programme grant as PI respectively, and similarly between 2020 and 2025 when the HRC reported all named investigators (NIs) for their funded grants, 78% and 88% of individuals were NIs on only one project or programme grant respectively.

Regardless of whether the salary funding

Table 1: Details of Health Research Council of New Zealand (HRC) funded projects and programmes.

HRC-funded projects		**HRC-funded programmes**
	N (%)	N (%)
2015–2025	413	52
Category[a]		
Preclinical	184 (45%)	19 (37%)
Clinical	229 (55%)	33 (63%)

Table 1 (continued): Details of Health Research Council of New Zealand (HRC) funded projects and programmes.

Institution		
University of Otago	170 (41%)	20 (39%)
The University of Auckland	146 (35%)	20 (39%)
Other[b] (23/7 institutions)	97 (23%)	12 (23%)
Principal investigators (PI)	286	45
Professor	153 (53%)	37 (82%)
Associate professor	57 (20%)	5 (11%)
Doctor	73 (26%)	3 (7%)
Other	3 (1%)	0 (0%)
Number of projects for a PI		
6	2 (0.7%)	
5	1 (0.3%)	
4	5 (1.7%)	
3	23 (8%)	
2	52 (18%)	7 (16%)
1	203 (71%)	38 (84%)
2020–2025		
Named investigators (NI)	1,193	321
Professor	317 (27%)	104 (32%)
Associate professor	152 (13%)	41 (13%)
Doctor	570 (48%)	126 (39%)
Other	154 (13%)	50 (16%)
Number of projects for a NI		
7	3 (0.3%)	
6	7 (0.6%)	
5	10 (0.8%)	
4	19 (1.6%)	1 (0.3%)
3	57 (4.8%)	4 (1.2%)
2	169 (14%)	34 (11%)
1	928 (78%)	282 (88%)

[a] Determined by one author (MB) reading the title and lay summary and classifying as preclinical or clinical. Where both categories of research co-existed in the same research grant, the dominant one was allocated.
[b] Twenty-three institutions for projects and seven for programmes.

path taken was university or externally funded, funders—and in particular the HRC—will require evidence of existing successful research by applicants for all these scholarships and grants. Prior funding will have been necessary to do such research and is also required to develop new research protocols and submit applications. Eight hours per week as a university academic is barely sufficient time to undertake literature reviews, develop protocols, write and submit funding applications, submit ethics applications and do the related university administrative tasks, at least when a researcher is starting out, and completely inadequate if at the same time the researcher is conducting ongoing studies. For externally funded researchers, funding will be required to do all these tasks, but either way, it is likely a lot of this work, probably the majority, will be done out-of-hours in the researcher's free time. Having invested a large amount of time into putting funding applications together, repeatedly being declined for funding has a considerable detrimental effect on morale, regardless of funding source.

Overall, even the most successful clinician-researcher is unlikely to be able to be achieve sufficient repeated success from publicly funded research grants and scholarships to fund their own salary for a substantive period of time.

Research funding

Between 2020 and 2025, the HRC research repository[4] lists all the NIs for the funded project grants. Over these 6 years, there were 227 funded project grants. The median number of NIs was seven, with a median of two professors, one associate professor and three doctors per project. Ninety-nine percent of projects had a professor or associate professor as an NI. The funding available for a project grant is NZ$1.2 million over 3–5 years (or NZ$1.44 million for clinical trials), which has not changed since 2010 (when it increased from "*proposals are not restricted in value but are generally less than $900,000 over 3 years*"), despite the increase in salaries of about 75%[5] and the consumer price index by about 45%[5] over this time.

Table 2 shows the budget for a hypothetical HRC project grant for clinical research with five NIs. Three are academics (a senior clinical professor, a clinical associate professor and a junior- to mid-career clinician as PI) and two run the study (one research nurse, one research officer/technician). Salaries are taken from relevant Association of Salaried Medical Specialists (ASMS), New Zealand Nurses Organisation (NZNO) or The University of Auckland websites. A 3-year grant with 0.16 FTE academic and 1.5 FTE non-academic gives a total salary budget of >NZ$500,000. Overheads are charged at 115%, totalling >NZ$600,000. The total budget for salaries alone is NZ$1.18 million without including any research expenses. MB's first successful HRC grant was in 2010 and budgeted NZ$453,000 over 4 years (8.56 FTE) for salary, NZ$516,000 at 114% for overheads and NZ$191,000 for research expenses (total NZ$1.16 million). Taking into account the increases in salaries (75%) and research expenses (45%) since 2010, the corresponding figures would be NZ$792,000 for salary, NZ$910,000 for overheads at 115% and NZ$277,000 for research expenses for a total budget of approximately NZ$2 million. The difference between what could be funded previously and what can be funded currently, both for salaries for academics and non-academics and research expenses, is stark.

Another factor contributing to funding difficulties is that previously "Time-Only" was allowed on applications where the contributions of senior academics in a university role would be listed as time-only and no funding would be required for their salaries. Some universities no longer permit this. Additionally, the HRC project rules require that the PI contribute at least 0.1 FTE and NIs at least 0.03 FTE. Table 2 shows the cumulative effect of all these requirements, meaning that there is insufficient funding in HRC project grants to undertake significant clinical research projects. The same argument applies to programme grants with clinical research components.

The overhead rate is another area where research funding is squeezed. The rate is negotiated between the institution and the HRC, and for The University of Auckland it is currently 115% of salaries. There are differing views on these overhead rates. For example, Universities New Zealand (a committee comprising all eight vice-chancellors of New Zealand universities) submitted to the University Advisory Group (an independent body established in response to a government directive and tasked with providing evidence-based advice on university operations and funding) that "*the need to charge overheads is unavoidable*" and that overheads "*are similar to those in other comparable research systems overseas and much lower than the rates charged by large private consultancies.*"[6] Whereas The University of Auckland states that "*our* [New Zealand's] *overhead structure is*

Table 2: Hypothetical budget for a 3-year clinical research proposal.

Research staff FTE (%) and FTE-adjusted salaries (NZ$)									
Named investigators	Grade	FTE (%)	Year 1	FTE (%)	Year 2	FTE (%)	Year 3		
Clinician	Scale 5[a]	10	20,898	10	21,488	10	22,078		
Professor (clinical)	Scale 15[a]	3	8,039	3	8,039	3	8,039		
A/professor (clinical)	Lowest[a]	3	5,561	3	5,738	3	5,915		
Research nurse	Step 6[b]	100	103,750	100	106,344	100	109,002		
Research officer/ technician	Mid-range[c]	50	35,000	50	35,875	50	36,772		
Annual total FTE and salary		166	173,249	166	177,485	166	181,807		
Total research staff FTE and salaries (all years)								**498**	**532,540.37**
Research working expenses									
Materials and research expenses									
Salary associated costs (Superannuation, ACC, etc.)—include rates below									
Superannuation			11,694		11,980		12,272		
ACC levy			277		284		291		
Total annual expenses			11,971		12,264		12,563		
Research working expenses (all years)									**36,799**
Overhead rate (OHR)									
Enter negotiated OHR for your institution (contact Health Research Council of New Zealand [HRC] if this is not available):									1.15
Total cost of research									
Total salaries (all years)									**532,540**
Overheads									
HRC budget includes an overheads component calculated from total salary multiplied by OHR. This funds indirect costs such as infrastructure									612,421
Total research working expenses (all years)									**36,799**
Total cost of research									**1,181,760**

Adapted from the standard HRC budget template. Salaries are taken from the published salary scales for [a]Association of Salaried Medical Specialists (ASMS), [b]New Zealand Nurses Organisation (NZNO), [c]The University of Auckland professional staff. Superannuation was calculated at 6.75% for all staff. The maximum budget is NZ$1.2 million; thus, NZ$18,240 is available for research expenses after salary costs are accounted for.

significantly higher than in other funding jurisdictions."[7] The University Advisory Group noted that New Zealand has "*a very high overhead rate compared to many other jurisdictions."*[8]

Part of the difficulty in comparing New Zealand's overhead rates to other countries is that different funding models are used. Nevertheless, such comparisons support the view that overheads in New Zealand are high.[9] For example, Australian universities typically use rates of 20–35%, United Kingdom funders will fund 80% of the full cost of the research expecting the university to fund the remaining 20%, and in the United States of America rates vary widely but typically are in the range of 30–70%. From the perspective of the researcher(s), overheads are punitive. If a research grant is not obtained, the university still provides the services that overheads fund, but if they succeed in obtaining a grant, a large proportion of it is taken for overheads and salaries that the university funds regardless. It is not clear why research success should turn a researcher into the "meat in the sandwich", caught between a university requiring more funding than they currently receive and a system that uses researchers' success to patch institutional shortfalls.

Past research success

New Zealand has a strong reputation for performing publicly funded clinical research.[10] Figure 1 shows the number of publications by year from the Scopus database, categorised as articles or reviews, published between 2000 and 2024, with a first or last author with an affiliation to New Zealand published in the four highest ranked medical journals. There were 358 publications meeting these criteria, with 353 individual authors. There appears to be a slow downward trend in such publications.

Table 3 shows the list of authors by number of publications. Of the 358 publications, 33% had a funding statement in Scopus (21% prior to 2018 and 73% in 2018 or later). Of the publications with funding statements prior to 2018, 22/60 (37%) were funded by the HRC, 18/60 (30%) by other New Zealand funders and 29/60 (48%) by either. From 2018 on, 30/57 (53%) were funded by the HRC, 18/57 (32%) by other New Zealand funders and 34/57 (60%) by either. Although there are a lot of missing data, the data suggest that a higher proportion of papers since 2018 have been at least partly funded by the HRC. Overall, the suggestion

Figure 1: Number of publications by year from 2000 to 2024 in the Scopus database, categorised as articles or reviews, with a first or last author with an author affiliation to New Zealand and published in *The New England Journal of Medicine*, *The Journal of the American Medical Association*, *The Lancet* or *The British Medical Journal*. The number above each bar is the number per year. The dotted line is a smoothed line of best fit (by loess) and the grey shading the 95% confidence intervals.

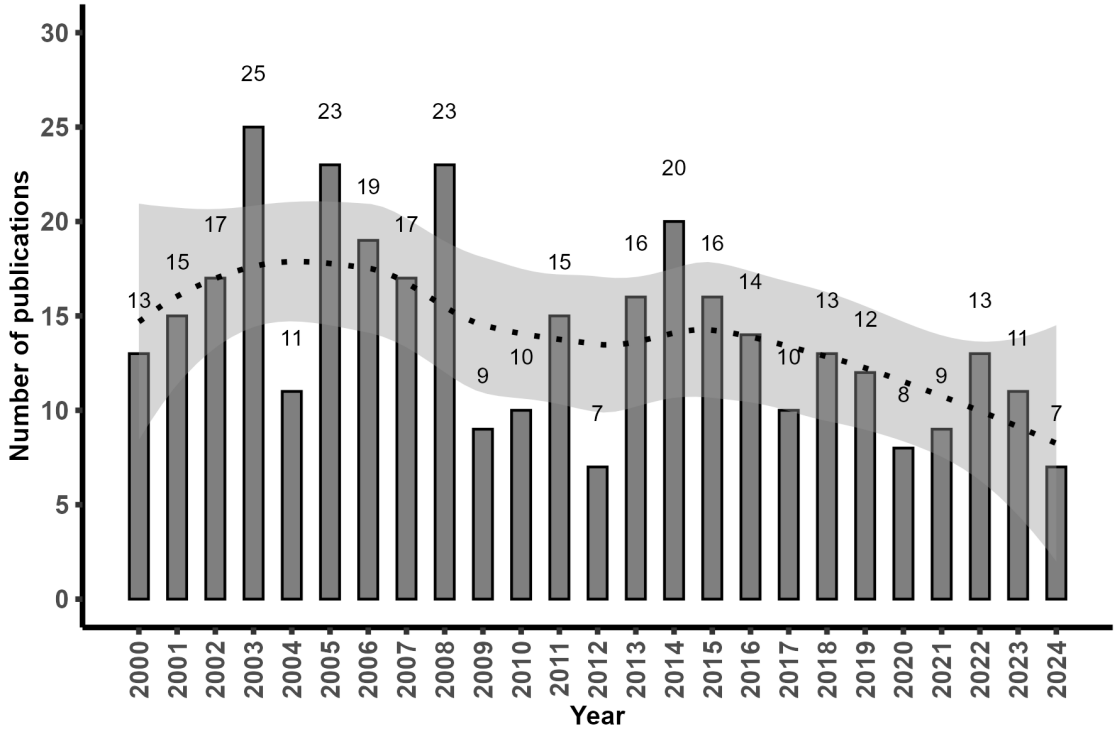

Table 3: First or last authors with New Zealand affiliations published in high impact journals 2000–2024.

n=14	**n=2**	**n=1**	**n=1**	**n=1**	**n=1**	**n=1**
Arroll, B.	Anderson, N.E.	Alawami, M.	Dobson, R.	Hodgson, C.	Mitchell, K.	Srinivasa, S.
n=11	Asher, M.I.	Alduhailib, H.J.	Douwes, J.	Hofman, P.L.	Mitchell, S.J.	Stacey, T.
Bolland, M.J.	Ashton, T.	Alexander, J.H.	Dowell, A.	Holden, A.	Moore, M.P.	Stamp, L.K.
Reid, I.R.	Bullen, C.	Alexander, T.	Duncanson, M.	Huang, Q.S.	Moore, P.	Stephenson, S.C.
n=10	Casswell, S.	Aljishi, M.	During, M.J.	Hudson, B.	Moyes, S.	Stewart, A.W.
Beasley, R.	Coulter, D.M.	Allen, J.	Eastwood, G.	Hughes, I.	Mpe, M.	Stewart, R.
n=9	Crane, J.	Ameratunga, R.	Eberhart-Phillips, J.	Hume, P.A.	Muir, P.	Stewart, R.A.H.
Beaglehole, R.	Croxson, M.	Ameratunga, S.	Ebmeier, S.	Jackson, R.T.	Mulder, R.	Sundborn, G.
n=8	Cundy, T.	Andersen, V.	Edwards, T.	James, P.	Murphy, R.	Surgenor, G.
Jackson, R.	Cutfield, W.S.	Anderson, T.J.	Ekramul Hoque, M.E.	Jardine, D.L.	Myburgh, J.	Swinburn, B.
n=7	Dalbeth, N.	Ardagh, M.W.	Elley, C.R.	Johnson, N.	Nowitz, M.	Swinburn, B.A.
Grey, A.	Davis, P.	Atkinson, J.	Ellison-Loschmann, L.	Jordan, A.	O'Grady, G.	Tai, V.
Harding, J.E.	Faasse, K.	Baker, S.	Feigin, V.L.	Jutel, A.	Oakley-Browne, M.	Tan, K.
n=6	Francis, P.A.	Barrow, C.	Fergusson, D.M.	Keall, M.D.	Ormiston, J.A.	Tawfiq, E.
Dalziel, S.R.	Frith, R.	Beasley, D.M.	Fernando, A.	Kendall, N.	Parry, G.J.	Taylor, D.R.
Farquhar, C.	Frizelle, F.	Bellomo, R.	Fitzharris, P.	Kenealy Prof, T.	Peake, S.L.	Taylor, R.W.
Rodgers, A.	Gluckman, P.	Bennett, H.	Flenady, V.	Kenealy, T.	Pearce, J.	Te Morenga, L.
n=5	Good-year-Smith, F.	Black, P.N.	Fletcher, L.	Kerr, J.A.	Peris-John, R.	Te Morenga, L.T.
White, H.D.	Gunn, A.J.	Bloomfield, A.	Foliaki, S.	Khan, M.I.	Petousis-Harris, H.	Than, M.
n=4	Hales, S.	Boden, J.M.	Forbes, J.F.	Kiro, C.	Pickering, N.	Thomson, G.
Baker, M.G.	Hancox, R.J.	Braun, V.	Franz, E.	Kypri, K.	Pokorny, V.	Thomson, W.M.
Blakely, T.	Holt, S.	Brogan, K.	Fukuzawa, R.	Langley, J.D.	Poole, P.J.	Tonkin, S.L.

Table 3 (continued): First or last authors with New Zealand affiliations published in high impact journals 2000–2024.

Chapman, P.	Hughes, R.J.	Brown, J.	Furness, S.	Lawes, C.M.	Porter, G.F.	Tran, K.B.
Falloon, K.	Janes, S.E.J.	Brownlee, W.J.	Fyfe, C.	Lawton, B.	Proctor, M.	Travis, E.
Gale, C.	Jull, A.	Bryder, L.	Gamble, G.D.	Lay-Yee, R.	Quarrie, K.L.	Troughton, R.W.
Murdoch, D.R.	King, J.S.	Buenz, E.J.	Gane, E.J.	Lensen, S.	Ramrakha, S.	Tunnicliffe, G.
Poulton, R.	Lawton, B.A.	Burnside, M.J.	Gane, Ed.	Lill, M.M.	Reeve, A.E.	Vernall, A.J.
Woodward, A.	Longhurst, H.J.	Campbell, P.J.	Ganeshaling-ham, A.	Lillie, J.	Reynolds, A.	Wallis, K.
n=3	Mangin, D.	Carr, J.	Ganly, P.	Logan, R.	Rizwan, S.B.	Waters, J.
Bloomfield, F.H.	Mann, J.I.	Carter, P.J.	Gentles, T.L.	Lucassen, M.F.G.	Roberts, H.	Weatherall, M.
Bonita, R.	McCowan, L.M.E.	Chan, B.C.Y.	Germann, R.	MacKle, D.	Robinson, E.M.	Webb, R.H.
Campbell, A.J.	McKinlay, C.J.	Chapman, M.	Gillespie, L.D.	Macmillan, A.	Roskvist, R.	Webb, S.A.
Campbell, D.	McKinlay, C.J.D.	Chisholm, N.	Gillespie, W.J.	Maessen, S.E.	Rowan, J.A.	Wells, J.E.
Crowther, C.A.	McNaughton, H.	Clark, H.	Gimpel, D.	Major, T.J.	Royds, J.A.	Wheeler, B.J.
Gane, E.	Mitchell, E.A.	Clark, M.A.	Gluckman, P.D.	Mann, J.	Sadleir, L.G.	Wilkinson, T.J.
Gillett, G.	Moyes, S.A.	Collins, M.G.	Gott, M.	Marks, G.B.	Savage, R.	Williams, B.F.
Kerse, N.	Newton-Howes, G.	Connor, J.	Grant, C.C.	Matheson, A.	Schep, L.J.	Williams, P.
Palmer, S.C.	Ng, J.	Coppell, K.J.	Grant, P.	Matlawene, M.	Scott, A.	Williams, S.
Paul, C.	Parkin, L.	Cormack, B.E.	Grant, V.J.	Maurice, P.	Scragg, R.	Williams, S.M.
Petrie, K.J.	Pearce, N.	Corwin, P.	Gurney, J.	May, C.S.	Selak, V.	Williamson, A.
Richards, A.M.	Potter, J.D.	Cox, B.	Gwynne-Jones, D.G.	Mays, N.	Shah, R.	Wilson, D.
Robertson, M.C.	Pylypchuk, R.	Crampton, P.	Hale, L.A.	McCormack, D.J.	Sharpe, N.	Wilson, P.D.
White, H.	Sadler, L.	Crozier, I.	Hardy, J.	McCowan, L.	Shaw, C.	Wong, C.
Wilson, N.	Schauer, C.	Cumming, J.	Harper, G.	McMahon, J.A.	Shedda, S.	Wong, C.-K.
Young, P.	Short, T.G.	Cunningham, C.	Harris, D.L.	McPherson, K.M.	Sheriff, A.	Woodward, L.J.
	Singh, S.	Dai, S.	Harris, R.	Mcintyre, P.B.	Simkin, S.K.	Yandle, T.G.

Table 3 (continued): First or last authors with New Zealand affiliations published in high impact journals 2000–2024.

	Skegg, D.C.G.	Daubé, J.	Hatcher, S.	Mcmillan, J.	Simon-Kumar, R.	Yeh, J.S.
	Sutherland, M.	Davidson, O.	Hatter, L.	Meissner, W.G.	Sizeland, P.	Yeoman, S.
	Walker, N.	Davie, G.	Herbison, G.P.	Menkes, D.B.	Skinner, J.R.	Young, P.J.
	Wells, S.	Deely, J.M.	Highton, J.	Menzies, R.	Slow, S.	Zacharias, M.
		Devlin, G.	Hill, A.G.	Merriman, T.R.	Smith, A.D.	de Bock, M.I.
		Devlin, N.	Hill, S.E.	Merry, A.F.	Smith, J.	
		Dickson, N.	Hills, T.	Merry, S.N.	Soh, M.C.	
		Dijkstra, B.	Hitchen, N.	Mills, G.D.	Soule, S.	

From the Scopus database, restricted to articles or reviews published in *The New England Journal of Medicine*, *The Journal of the American Medical Association*, *The Lancet* or *The British Medical Journal* between 2000 and 2024 with the first or last author having a New Zealand affiliation. Names and initials were used directly from Scopus with no attempt to confirm affiliations or identify duplicates.

is that while the HRC is funding a higher proportion of higher impact publications, the overall number of such papers is falling steadily, which is likely to affect New Zealand's reputation around clinical research.

Conclusion

In summary, while the HRC is now prioritising clinician-researchers, the combination of university job structures giving insufficient time for research, the lack of alternative options for long-term sustainable research salary funding, the low success rates for HRC research grant and scholarship funding applications, the low repeated success rates for HRC grants and programmes and the lack of increases in research funding for more than 15 years despite large increases in wage and research expense costs mean that, currently, sustaining a career as a clinician-researcher in New Zealand is not viable. Clinician-researchers may have some success with research grants, but these will likely be only available for short-term, relatively small clinical projects. Relying on industry-funded research may be a possibility in some fields, but it is unlikely to be sufficiently sustainable to fund a salary for an entire career. When asked by junior colleagues about pursuing research-based careers, our standard approach is to caution them about the near-impossibility of fulfilling such an ambition in even the medium term.

COMPETING INTERESTS
Nil.

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