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Narrative Review

The Wounded Specialty: Burnout, Litigation, Workforce Challenges, and the Future of Obstetrics and Gynecology

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Received: August 01, 2026; **Published:** August 30, 2026

Abstract

Background: Obstetrics and gynecology (O&G) is under sustained pressure from clinician exhaustion, an unsettled medico-legal environment, loss of experienced staff, and growing demand for complex women's healthcare. These difficulties rarely occur in isolation. Together, they shape access to care, continuity, patient experience, and the ability of services to remain safe over time.

Objective: To examine how burnout, litigation, and workforce instability interact in O&G, and to outline practical ways of making the specialty more sustainable, professionally rewarding, and responsive to patients' needs.

Methods: A narrative review was undertaken using peer-reviewed research, systematic reviews, workforce reports, professional guidance, and relevant policy documents. The literature considered clinician wellbeing, complaints and defensive practice, recruitment and retention, multidisciplinary working, digital care, artificial intelligence (AI), precision medicine, genomics, and contemporary screening approaches.

Findings: The evidence points chiefly to conditions of work rather than individual weakness. Persistent rota gaps, heavy workload, emotional strain, limited recovery time, administrative demands, poor workplace culture, and lengthy complaints procedures all contribute to burnout and may encourage defensive practice or decisions to reduce hours and leave the specialty. Recruitment alone is therefore unlikely to resolve the problem. More durable responses include adequate staffing, protected training and rest, flexible career structures, phased retirement, multidisciplinary and continuity models, simpler administrative processes, fair investigation of adverse events, timely peer support, patient involvement in service design, and well-governed hybrid care. AI could assist with documentation, education, imaging, fetal surveillance, risk assessment, and workflow, but its use should depend on external validation, human oversight, privacy safeguards, monitoring for bias, and clear lines of responsibility. Genomic and precision approaches-including cell-free DNA screening, carrier screening, microarray, sequencing, and molecular tumour classification-offer opportunities for more accurate diagnosis and targeted treatment, although they also increase the need for counselling, specialist input, equitable access, and protection against overdiagnosis.

Conclusion: The future of O&G depends on more than clinical innovation. It also requires workable conditions, proportionate accountability, meaningful partnership with patients, and careful adoption of new technology. Clinician wellbeing should be treated as a measure of service quality and patient safety, with progress judged through retention, access, equity, patient outcomes, and the length and quality of professional careers.

Keywords: *Obstetrics and Gynecology; Burnout; Workforce Sustainability; Litigation; Defensive Medicine; Patient-Centred Care; Artificial Intelligence; Precision Medicine; Genomics*

Introduction

Obstetrics and gynecology combines preventive care, reproductive medicine, acute maternity care, complex surgery, oncology, and lifelong women's health. Its breadth is a major source of professional meaning, yet it also creates distinctive operational and emotional demands. Clinical work is frequently time-critical, outcomes may affect more than one patient, and decisions made under uncertainty are often reviewed with hindsight [2,10-14].

The central challenge is not a single shortage or wellbeing metric but a reinforcing system: chronic workload and poor recovery contribute to burnout; burnout drives reduced hours, absence, and departure; vacancies increase workload; and medico-legal anxiety compounds distress and defensive practice. Recent specialty data underscore the urgency, with high reported burnout risk, substantial work beyond contracted hours, and meaningful intention to leave. Workforce sustainability must therefore be considered alongside safety, quality, and equity rather than treated as a separate human-resources concern [2,10-14].

This review examines the interconnected effects of burnout, litigation, and workforce instability and presents a practical reform agenda. Particular attention is given to recruitment and retention, mitigation of burnout and medico-legal pressure, patient-centred quality, AI-enabled practice and education, and the implications of precision medicine, genetic profiling, and advanced screening technologies [2,10-14].

Methods

This article is a short narrative review. Literature was identified from peer-reviewed reviews and primary studies, professional-society guidance, workforce reports, and international policy documents. Searches focused on O&G burnout, clinician wellbeing, complaints and defensive medicine, workforce recruitment and retention, multidisciplinary and continuity models, telehealth, AI, precision medicine, prenatal genetics, advanced screening, and gynecologic oncology. Recent and high-quality publications were prioritized, while landmark sources were retained where they established definitions or organizational frameworks [3,4].

Evidence was synthesized thematically rather than quantitatively. The review does not claim systematic-review completeness, pooled prevalence, or causal certainty. Its purpose is to connect evidence across clinical, workforce, organizational, legal, and technological domains and translate that evidence into an actionable agenda for the specialty [3,4].

Burnout, complaints, and workforce instability

Burnout is characterized by exhaustion, cynicism or depersonalization, and reduced professional efficacy. In O&G, risk accumulates through long or unpredictable shifts, rota gaps, increasing clinical complexity, emotionally difficult outcomes, administrative work, inadequate rest, limited control, and insufficient support. Trainees face the additional pressure of examinations, competency requirements, and competition between service delivery and supervised learning. These are principally organizational exposures; individual resilience programmes may help some clinicians but cannot compensate for unsafe staffing or chronically dysfunctional work design [1-9,15-18].

The consequences extend from clinician health to communication, teamwork, continuity, and safety. Cross-sectional evidence cannot resolve every direction of causality, yet associations between burnout, self-reported errors, reduced patient satisfaction, and intention to leave are consistent enough to justify organizational action. Psychological safety, belonging, autonomy, fair supervision, and access to development are protective features of healthier workplaces [1-9,15-18].

Medico-legal pressure amplifies this cycle. A complaint, serious-incident review, regulatory process, or claim may continue for months or years and can produce anxiety, shame, loss of confidence, and professional isolation even when no fault is established. Defensive medicine may follow, including unnecessary tests, referrals, documentation, or intervention undertaken primarily to reduce perceived

legal exposure. In obstetrics, where decisions are time-sensitive and adverse outcomes can be profound, hindsight bias may further intensify fear [1-9,15-18].

A credible alternative is a just culture that distinguishes human error, at-risk behaviour, reckless conduct, and system failure. Investigations should be timely, proportionate, transparent, and focused on learning. Immediate peer support, confidential psychological care, open communication with patients and families, and disclosure-and-resolution approaches can preserve accountability without making avoidable harm to staff part of the safety process [1-9,15-18].

Making the specialty attractive and sustainable

Recruitment begins before specialty selection. Medical students and junior doctors need meaningful exposure to the specialty's intellectual breadth, procedural skills, continuity of relationships, research opportunities, and social value. Visible role models, structured mentorship, respectful teams, and high-quality supervision can counter an image defined only by rota intensity and litigation. Recruitment messages should be honest about pressures while demonstrating that those pressures are being addressed [11,12,19].

Retention deserves equal weight. Predictable rotas, safe staffing, protected rest and training, flexible and less-than-full-time pathways, job sharing, portfolio careers, childcare-sensitive scheduling, phased retirement, and opportunities in education, research, leadership, quality improvement, and digital innovation can extend career longevity. Senior clinicians should be supported to reduce high-intensity duties while retaining roles in mentorship, supervision, complex decision-making, and succession planning [11,12,19].

Workforce plans should measure more than headcount. Vacancy rates, turnover, unfilled shifts, overtime, sickness absence, training access, intention to leave, psychological safety, patient access, and continuity provide a more realistic picture of capacity. These indicators should be stratified by career stage and work setting so that interventions can target where attrition risk is greatest [11,12,19].

Patient-centred service quality and workforce redesign

Patient-centred care is not an additional initiative; it should organize service design. Continuity, shared decision-making, clear communication, culturally responsive care, trauma-informed practice, and co-production with women and families can reduce fragmentation and strengthen trust. Quality frameworks should combine clinical outcomes with patient-reported experience, access, equity, continuity, and workforce wellbeing [10,20-23].

Multidisciplinary care allows each professional to work at the top of their competence. Midwife-continuity models for appropriate pregnancies can improve continuity and may reduce selected interventions, while obstetric expertise remains available through explicit escalation pathways. Advanced practice nurses, specialist midwives, pharmacists, physiotherapists, psychologists, and genetic counsellors can expand access in contraception, menopause, pelvic-floor care, survivorship, prenatal counselling, and follow-up. Implementation requires role clarity, shared governance, adequate staffing, and leadership that addresses professional boundaries rather than simply shifting work [10,20-23].

Regional networks and hybrid care can further improve resilience. Virtual multidisciplinary meetings, shared referral pathways, remote monitoring, and telehealth may reduce travel and improve access, particularly where specialist expertise is scarce. Digital pathways require clear criteria for in-person review, secure systems, accessibility support, and monitoring for digital exclusion [10,20-23].

Artificial intelligence in practice, education, and workflow

AI may contribute most immediately by reducing low-value administrative work. Ambient documentation, coding support, scheduling, referral triage, inbox prioritization, evidence retrieval, and routine patient communication could return time to clinical care. In education,

AI-enabled simulation, adaptive learning, feedback, and case generation may support individualized development, although outputs must be checked and assessment integrity protected [24-29,38-40].

Clinical applications under investigation include ultrasound interpretation, cardiotocography, reproductive-medicine selection tools, gynecologic imaging and pathology, prediction of pregnancy complications, and treatment-response modelling. These systems should augment rather than replace professional judgement. Before deployment, tools require external validation in representative populations, comparison with usual care, prospective evaluation of clinical benefit, usability testing, calibration monitoring, and assessment of unintended workload [24-29,38-40].

Responsible adoption also requires transparent governance. Data provenance, privacy, cybersecurity, explainability, bias, model drift, procurement standards, vendor accountability, and medico-legal responsibility must be explicit. Human oversight and an auditable route to challenge an output are essential. AI literacy should therefore become part of undergraduate, postgraduate, and continuing education, enabling clinicians to assess performance, recognize limitations, communicate uncertainty, and retain independent judgement [24-29,38-40].

Precision medicine, genomic profiling, and advanced screening

Precision medicine is reshaping prenatal diagnosis, reproductive care, and gynecologic oncology. Cell-free DNA screening, expanded carrier screening, chromosomal microarray, and sequencing-based diagnostics can identify a wider range of conditions and refine diagnostic pathways. In oncology, molecular classification, homologous-recombination deficiency, mismatch-repair status, and other biomarkers increasingly inform prognosis and targeted treatment [30-37].

Greater technical capability does not automatically create better care. Screening is not diagnosis; positive results may require confirmatory testing, and variants of uncertain significance may create anxiety and complex follow-up. Clinicians need genomic literacy, access to genetics professionals, and sufficient time for pre-test and post-test counselling. Consent should explain the scope and limitations of testing, possible incidental findings, residual uncertainty, and the implications for relatives [30-37].

Equity must be designed into implementation. Unequal access to testing, under-representation in reference datasets, variable insurance or public coverage, and shortages of genetics expertise may widen disparities. Governance should address data stewardship, recontact policies, discrimination risk, test appropriateness, and avoidance of overdiagnosis. Precision care should remain patient-centred and evidence-based rather than technology-driven [30-37].

Implementation priorities

Priority	Immediate actions	Measures
Recruit and retain	Meaningful early exposure; mentorship; flexible careers; phased retirement; protected training	Vacancies, turnover, intention to leave, training access, career longevity
Reduce burnout	Safe staffing; predictable rotas; rest; administrative simplification; supportive leadership	Burnout, overtime, sickness absence, psychological safety
Improve medico-legal processes	Just-culture review; timely investigation; peer support; open disclosure; systems analysis	Process duration, staff support uptake, recurring safety themes, defensive-practice indicators
Strengthen patient-centred quality	Continuity; shared decisions; co-design; culturally responsive and trauma-informed care	Patient experience, access, equity, continuity, clinical outcomes
Adopt technology responsibly	Prospective validation; human oversight; bias and privacy controls; AI and genomic literacy	Clinical benefit, workload effect, subgroup performance, safety events, digital access

Table 1: *Priority actions for a sustainable O&G workforce.*

Research priorities and limitations

Future research should move from repeated prevalence surveys toward longitudinal and intervention studies. Priority questions include which organizational changes improve retention, whether just-culture and peer-support programmes reduce distress and defensive practice, how continuity and hybrid models affect outcomes and equity, and whether AI genuinely reduces workload while improving care. Workforce indicators should be linked prospectively to patient outcomes, experience, access, cost, and safety [3,4,19].

This review is limited by its narrative design, heterogeneity of definitions and measurement tools, reliance on cross-sectional and self-reported evidence, and concentration of published data in high-income settings. Workforce structures, legal systems, resources, and scopes of practice vary substantially; interventions therefore require local adaptation and evaluation [3,4,19].

Conclusion

O&G is at a strategic inflection point. Burnout, litigation, and workforce instability are not parallel problems but a single reinforcing system: poor work design erodes wellbeing; attrition intensifies workload; and complaints or adverse events can further diminish confidence and willingness to remain in high-risk practice. The specialty cannot recruit its way out of this cycle while the conditions that drive departure remain unchanged [2,3,5,11,12,24,30].

A forward-looking response must make O&G both attractive and practical across an entire career. Early exposure, positive role models, protected supervision, and diverse career opportunities can strengthen recruitment. Retention requires safe staffing, predictable work, flexible pathways, protected development, meaningful recognition, and opportunities for senior clinicians to remain through mentorship and phased retirement. Wellbeing must be measured alongside activity and waiting times because a service that meets short-term targets by exhausting its workforce is not sustainable [2,3,5,11,12,24,30].

Burnout reduction must focus on redesigning work, not teaching clinicians to endure harmful conditions. Medico-legal reform should combine fair accountability with timely, systems-based investigation, open communication, and immediate support after adverse events. Patient partnership should shape every redesign through continuity, shared decisions, culturally responsive communication, and transparent measures of experience, equity, and outcome [2,3,5,11,12,24,30].

AI, telehealth, genomics, and advanced screening can improve practice only when they solve real clinical problems without creating new inequities or burdens. Human oversight, external validation, privacy, bias monitoring, informed consent, genetic counselling, and clear responsibility are prerequisites. These technologies should expand professional capability and patient choice, not substitute for judgement, relationships, or adequate staffing [2,3,5,11,12,24,30].

Ultimately, sustaining the specialty requires aligned action from healthcare organizations, educators, professional bodies, regulators, indemnifiers, policymakers, technology developers, and patients. Success should be judged by whether clinicians can remain and thrive, whether women receive timely and equitable care, and whether innovation improves outcomes without compromising trust. Protecting the O&G workforce is therefore not separate from protecting women's health; it is one of its essential conditions.

Author Contributions

All authors contributed to the conception and scope of the review, interpretation of the literature, critical revision of the manuscript, and approval of the final version for submission. All authors accept responsibility for the integrity of the work.

Funding Support

This work received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflicts of Interest

The authors declare no conflicts of interest.

Ethics Approval

Not applicable. This article is a narrative review of published literature and did not involve human participants, identifiable personal data, or animals.

Consent to Participate and Consent for Publication

Not applicable.

Data Availability

No new datasets were generated or analysed for this narrative review.

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Volume 15 Issue 9 September 2026