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Opinion

Professional Fulfilment and the Making of a Lasting Legacy in Obstetrics and Gynaecology

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Abstract

Obstetrics and gynaecology offers considerable scope for a rewarding professional life, yet conventional measures of success describe only part of a worthwhile career. Operative volume, academic appointments and institutional office reveal little about whether women felt heard, whether colleagues became more capable, or whether services remained safe after a respected clinician departed. This special article examines the idea of a professional bucket list as a starting point for a more considered account of fulfilment and legacy. Drawing on selected literature concerning professionalism, respectful maternity care, shared decision making, patient safety, mentorship, physician wellbeing and retirement, it proposes a career agenda organised around contributions that retain value beyond the individual encounter. These include maintaining clinical judgement, restoring function and dignity, protecting reproductive autonomy, strengthening teams, improving access, undertaking useful scholarship and preparing successors. The proposed agenda is an ethical and practical argument, not a validated measure of career success. Ambition requires scrutiny when it encourages unnecessary intervention, professional indispensability or achievement at the expense of health and relationships. Institutions also bear responsibility: personal commitment cannot compensate indefinitely for unsafe workloads, discrimination or inadequate resources. A lasting professional legacy rests on demonstrable benefit to women, knowledge and capability shared with others, and services able to function without dependence on one practitioner. Such a career should remain compatible with a meaningful life beyond medicine.

Keywords: *Obstetrics and Gynaecology; Professional Fulfilment; Clinical Leadership; Mentorship; Patient Safety; Career Development; Professional Legacy*

Introduction

What should an obstetrician and gynaecologist hope to have accomplished by the end of a career? Early answers usually concern qualification, technical independence and a secure appointment. Later, the list may expand to include advanced surgery, subspecialist recognition, publication or departmental leadership. Such ambitions provide direction during demanding training and recognise years of disciplined work. They do not, however, explain what makes a career worth the personal and collective investment it requires.

A professional bucket list gives this question an accessible, if imperfect, form. Applied uncritically to medicine, however, it risks turning patients into occasions for professional accomplishment. An uncommon operation or a dramatic rescue may become an achievement to

acquire, with too little attention to the woman's experience. Women do not seek care to complete a clinician's aspirations. Any account of professional fulfilment must therefore begin with the obligations of practice and examine personal ambition against them. The physician charter places patient welfare, autonomy and social justice at the centre of professionalism [1].

The breadth and intimacy of obstetrics and gynaecology give this question particular urgency. Its work includes emergencies with irreversible consequences alongside conditions that alter ordinary life over many years. It involves intimacy, uncertainty and decisions shaped by family, culture and personal identity. A career may include extraordinary clinical moments, but much of its value accumulates through less conspicuous acts: taking persistent symptoms seriously, explaining a difficult choice, supervising a colleague or ensuring that a referral reaches the appropriate service.

These less visible contributions deserve a place in how clinicians plan and assess their professional lives. The article argues for ambitions that can be assessed through their benefit to women and the capability they leave in others. It also considers what medicine can reasonably ask of the clinician. A worthwhile career should permit responsibility, intellectual satisfaction and attachment to work without requiring the abandonment of health, relationships or a future beyond clinical employment.

Scope and approach

This is a reflective special article informed by selected literature, not a systematic review. Sources were identified through targeted searches of PubMed records, journal material and World Health Organization publications addressing professionalism, childbirth experience, decision making, clinical improvement, mentoring, wellbeing and retirement. The discussion brings established contributions into conversation with specialty-specific evidence. No exhaustive search, formal risk-of-bias assessment or pooled analysis was undertaken. Recommendations represent an ethical and practical interpretation of that literature rather than tested effects of a career intervention.

The distinction matters because professional fulfilment has no single agreed meaning. Satisfaction with work, freedom from burnout, academic productivity and a sense of purpose overlap without being interchangeable. Evidence about interventions in obstetrics and gynaecology is also uneven. A specialty-specific scoping review found a limited intervention literature, much of it concerned with individual approaches and preliminary studies. [2] The agenda offered here is therefore intended to support reflection across different careers and circumstances.

Professional legacy is understood here as a contribution whose benefit persists through other people, established processes or accessible knowledge. It does not require a named centre, an endowed position or recognition after retirement. Many contributions are inseparable from the work of midwives, nurses, anaesthetists, administrators and other colleagues. Attribution should reflect that shared effort. Nor is persistence alone sufficient evidence of value: a practice can survive because authority protects it, despite having become unhelpful. A legacy must remain open to examination and replacement. Women using the service, including those dissatisfied with it, should have opportunities to inform that judgement. This definition places continuing benefit ahead of how the clinician wishes to be remembered. The relevant question is whether the contribution continues to deserve its place in care.

Defining achievement through the lives of women

The effect of care on the woman receiving it should guide any assessment of achievement. Technical success remains essential, but it does not exhaust the meaning of a successful encounter. A woman may leave hospital physically recovered yet uncertain why an intervention occurred. Another may continue to experience symptoms but feel supported by a clear explanation, an agreed plan and reliable access to review. Professional achievement should make room for both clinical outcomes and the experience of obtaining care.

The WHO recommendations on intrapartum care explicitly situate childbirth within a woman-centred, rights-based approach [3]. This gives professional aspiration a practical direction. A clinician might aim to improve how women are informed during emergencies, protect

privacy in crowded facilities or make interpretation reliably available. These are attainable contributions with consequences beyond personal bedside manner. They require attention to how the service behaves when demand is high and familiar staff are absent.

Mistreatment during childbirth also cannot be explained solely through the disposition of individual practitioners. Bohren and colleagues described interpersonal mistreatment alongside failures of professional standards and constraints within health systems [4]. Personal courtesy matters, and clinicians with influence should also examine the conditions that permit humiliation, coercion or neglect. An achievement worth pursuing may be the removal of an accepted practice that women have long found distressing.

Gynaecology offers equally important, quieter opportunities. Heavy bleeding, chronic pelvic pain, prolapse and urinary symptoms can narrow a woman's working and social life. Care should establish which limitations matter to her before choosing treatment. Restoring the ability to leave home confidently or to work without disruption may be more meaningful than the anatomical result alone. An account of achievement should describe what women regained and acknowledge those for whom treatment did not deliver the hoped-for benefit. Seeking feedback from women themselves helps keep that judgement grounded in the realities of receiving care.

Clinical mastery and the discipline of restraint

Clinical competence requires deliberate attention throughout a career. Women are entitled to practitioners who know the relevant anatomy, recognise deterioration and perform procedures within their capabilities. Expertise, however, is more demanding than confidence or accumulated case numbers. It includes preparation, careful selection, anticipation of difficulty and an honest response when the operation or clinical course departs from expectation.

Evidence from another surgical specialty illustrates why this matters. In bariatric surgery, peer assessments of operative skill were associated with postoperative complication rates [5]. The findings cannot establish the same relationship for every gynaecological procedure, but they challenge the assumption that seniority alone adequately demonstrates proficiency. Direct observation and constructive criticism should remain welcome long after formal training has ended.

Within obstetrics and gynaecology, mastery should include the ability to recommend against an intervention. A surgeon may gain recognition for complex procedures while the women spared unnecessary surgery remain invisible. The decision to continue medical management, seek another opinion or refer to a colleague can require considerable professional confidence. Career plans should reward sound judgement without making procedural novelty the principal marker of advancement.

This is especially relevant when adopting new technology. Training opportunities, institutional enthusiasm and commercial visibility can create pressure to expand indications before experience is secure. A clinician should ask whether the proposed technique addresses a patient need, whether an established alternative remains appropriate, and how complications will be managed. Learning should occur within supervision, credentialling and outcome review appropriate to the procedure. Sustained competence depends on recognising limits and ensuring that appropriate support remains available as practice develops.

Women should not carry the hidden cost of a clinician's desire to remain technically ambitious. Informed discussion must distinguish established care from innovation and explain relevant uncertainty. Equally, excessive fear of criticism should not prevent appropriately governed development. Professional maturity lies in keeping improvement accountable to patient benefit and in accepting that expertise sometimes means inviting another person to operate.

Protecting autonomy in intimate clinical decisions

Obstetrics and gynaecology repeatedly brings professional recommendations into contact with deeply personal preferences. Fertility treatment, mode of birth, contraception, hysterectomy and the management of pregnancy complications may carry different meanings

for different women. An apparently efficient decision can become a poor one if the clinician has misunderstood the outcome the woman values most.

Shared decision making offers a way to address this difficulty. Elwyn and colleagues describe a process in which options are introduced, their implications explored and preferences supported through deliberation [6]. Improving these conversations is a substantive clinical ambition. Attendance at a communication course is only a beginning. The question is whether consultations allow women to understand alternatives, express uncertainty and make decisions without being hurried into agreement.

Clinical urgency sometimes narrows the available time, but it does not remove the obligation to explain. Communication during an emergency should be proportionate to circumstances and revisited afterwards. A later conversation may be necessary to explain why events unfolded quickly, answer questions and discuss consequences for future care. Professional satisfaction should include having provided that explanation, even when the clinical outcome was favourable and the service considers the episode complete.

Respect for autonomy also requires attention to the clinician's own assumptions. A desire for pregnancy should not be presumed, nor should declining fertility treatment, surgery or a recommended delivery plan be treated as evidence of irresponsibility. Family involvement may be welcome, but the woman's own wishes must be heard and respected. Interpretation, privacy and adequate time are service requirements that make these principles possible. A lasting contribution would be to help establish a consultation culture in which a woman's disagreement prompts further understanding rather than irritation or withdrawal of care.

Making emergency care dependable

Few clinical experiences are remembered as vividly as a successful emergency intervention. Obstetric emergencies can demand exceptional speed and skill, and successful intervention deserves recognition. Yet a service organised around the availability of a particular rescuer remains vulnerable. A more durable ambition is to make the appropriate response dependable across shifts, professional groups and levels of experience.

Draycott and colleagues reported an association between the introduction of obstetric emergency training and improved neonatal outcomes in a single maternity unit [7]. Its observational design limits causal inference, but the study illustrates how educational activity can be linked to clinical outcomes rather than attendance alone. For the clinician considering a lasting contribution, the lesson is to connect training with the actual work of the team and the problems encountered in its own environment.

Improvement also requires organisation beyond the emergency room. A California perinatal quality collaborative reported reduced severe maternal morbidity associated with a structured approach to obstetric haemorrhage [8]. Such work directs attention to readiness, recognition and coordinated response. It provides a model of achievement shared among many contributors rather than attributed to one operator. Its transfer to another setting requires attention to resources, baseline performance and implementation conditions.

A useful improvement project might address a recurring weakness: delayed escalation, unavailable equipment, uncertain responsibilities or an unreliable handover. Someone must take responsibility for an agreed change and review whether care improves. Repeated simulation can expose problems, but identifying them without securing action risks making training another ritual. Leadership is demonstrated when lessons alter practice. The resulting achievement may attract little public recognition, yet its value lies in the woman who receives timely care from a team that already knows how to work together.

Building services that can outlast their founders

Starting a specialist service is an attractive career ambition. An endometriosis centre, an adolescent clinic or a pathway for complex pelvic floor disorders may answer a genuine unmet need. The challenge begins when the service must function reliably within ordinary staffing, budgets and referral arrangements. Its survival depends on practical arrangements that enthusiasm alone cannot supply.

Service development should begin with a defined population and a clear account of the problem. Which women are waiting, where does care currently fail, and what can the proposed service reasonably improve? Clinical scope must match available expertise and support. A tertiary clinic that accepts every referral without triage may become inaccessible to the women who most need its specialist resources. Conversely, moving care elsewhere without the necessary capability merely transfers the burden.

The founder should plan for absence from the beginning. Referral criteria, clinical responsibilities, administrative processes and escalation routes need to be understood by more than one person. Outcome review should include complications and experience of care, not simply activity. Patients should know how to obtain help when the lead clinician is unavailable. These arrangements can feel less rewarding than visible clinical expansion, but they determine whether the service is dependable.

Women should also help define what a successful service looks like. A consultation group should include people whose care was delayed or disappointing, rather than relying exclusively on satisfied volunteers. Their observations can reveal burdens absent from activity reports, including repeated travel, contradictory advice and uncertainty about responsibility. Feedback needs a visible response, with an explanation when a requested change cannot be made. Women should be able to see how their participation has influenced decisions about care.

An important test of legacy is what happens during leave, illness or departure. If the pathway collapses, the institution has retained an individual practice rather than established a service. Clinicians should therefore share knowledge, develop deputies and welcome improvements introduced by successors. Persistence of the founder's exact design is not the objective. A service that continues to adapt safely may honour the original purpose more faithfully than one that preserves familiar arrangements after they have ceased to meet need.

Mentoring successors without creating dependence

Mentoring extends teaching into a sustained interest in another person's development. It requires respect for ambitions that may differ from one's own. The clinician who supervises a difficult procedure provides immediate educational value. The mentor who helps a younger colleague gain opportunities, recover confidence or make an independent career decision may influence years of practice.

A systematic review by Sambunjak and colleagues found that mentoring was reported to influence career development and academic productivity, while also identifying limitations in the underlying evidence [9]. The findings support mentorship while leaving uncertainty about which arrangements work best and for whom. Relationships vary, and access to effective mentors is itself a matter of fairness. Informal selection can repeatedly favour those already comfortable within established professional networks.

For an experienced obstetrician and gynaecologist, a useful aspiration is to leave several colleagues more capable of working independently. That requires progressive responsibility, clear feedback and willingness to let others receive credit. Opportunities should include leadership and scholarship as well as technical cases. Supervision must remain responsive to patient safety, but indefinite restriction can protect the supervisor's position more than the learner's development.

Mentorship also needs boundaries. A trainee should be able to question advice, change interests or seek support elsewhere without fear of professional penalty. The mentor cannot become the sole source of approval or opportunity. Departments should make supervision and sponsorship more transparent, particularly for clinicians working less than full time or outside the most visible academic pathways. A successful mentoring relationship eventually changes: dependence diminishes, disagreement becomes easier, and the former trainee contributes knowledge that the mentor does not possess. Accepting that change is part of the achievement.

Scholarship that earns its place

Publication can preserve knowledge, challenge accepted practice and influence services far beyond the author's institution. It can also become an activity detached from a useful question. A professional bucket list organised around a target number of papers risks rewarding repetition, weak methods and conclusions that exceed the data. Academic ambition should begin with what requires explanation and who might benefit from the answer.

Chalmers and Glasziou drew attention to avoidable waste across the production and reporting of research [10]. For practising clinicians, this invites a straightforward discipline: examine what is already known before beginning another study, involve appropriate methodological expertise and choose outcomes that matter. A modest, well-conducted investigation of a service problem may contribute more than a larger project whose principal purpose is another publication.

Clinical improvement also deserves careful reporting. SQUIRE 2.0 provides guidance for explaining the intervention, context, methods and interpretation of improvement work [11]. A department that changes referral triage or emergency escalation should distinguish implementation from evaluation. Increased activity does not automatically demonstrate improved access, and an outcome observed after a change does not by itself establish causation. Honest accounts of unsuccessful or incomplete improvement can be valuable when their limitations are clear.

Intellectual reliability should be the enduring scholarly ambition. Authors should represent uncertainty accurately, recognise collaborators fairly and resist pressure to give a local observation universal significance. Women and colleagues who contribute data are entitled to more than an impressive title. The work should answer its question as well as available methods permit and make its findings accessible. A lasting scholarly contribution may be a single paper that changes how a difficult problem is understood, a teaching resource that remains useful, or a carefully documented service evaluation that prevents another institution from repeating an avoidable mistake.

Responding to harm with accountability and humanity

No serious account of a clinical career can exclude adverse outcomes. Obstetrics and gynaecology includes events that remain painful long after the record has been closed. Some arise despite appropriate care; others involve preventable failures. Professional fulfilment cannot depend on believing that a good doctor will never be associated with harm. It must include the capacity to respond truthfully when harm occurs.

Wu's discussion of clinicians affected by medical error helped draw attention to their need for support [12]. Acknowledging clinicians' distress must not displace the needs of the woman and family whose lives have been affected. Their needs for information, treatment, acknowledgement and fair investigation remain central. Support for staff and accountability to patients should proceed together, with neither used to obstruct the other.

Colleagues can help an affected clinician remain engaged with disclosure, investigation and learning. Practical support can include accompanying someone to a difficult meeting, ensuring access to confidential care and helping them prepare an accurate account. It should not involve rehearsing a defensive narrative or discouraging disclosure. Equally, investigation should avoid treating distress as evidence of guilt or assuming that an unfavourable outcome proves individual incompetence.

Responsibility continues after the immediate event and its investigation. Departments need to determine whether agreed improvements occurred and whether women received promised follow-up. Clinicians returning to work may need supervision or changes in duties appropriate to their circumstances. The objective is safe practice with learning that survives the investigation. A career marked by an honest response to failure may leave a stronger professional example than one carefully presented as a succession of unqualified successes. What matters is the integrity of the response and the effort to reduce recurrence.

Using influence to improve access and fairness

Professional influence usually grows unevenly. Some clinicians acquire formal authority; others become trusted advisers without holding office. Both can use their position to identify women who encounter avoidable barriers to care. Waiting times, language, cost, geography and referral rules may shape clinical outcomes before a consultation begins. A career confined to what happens inside the consulting room can overlook these determinants of access.

The Lancet Commission on Global Surgery situated access to safe and affordable surgery and anaesthesia within health-system development [13]. For obstetricians and gynaecologists, that wider perspective makes global contribution a legitimate ambition. Such work should respond to priorities identified by local clinicians and communities. A sustained partnership to improve supervision or emergency pathways may be more valuable than a brief visit dominated by procedures that local teams cannot subsequently support.

International work requires reciprocity. Visiting clinicians should understand their limits, work within agreed governance and ensure that postoperative care is available. Local colleagues should help determine the agenda and receive appropriate recognition for the work. Equipment and techniques need to be maintainable in the setting where they are introduced. The same principles apply to remote education: accessibility and relevance matter more than the prestige of the speaker.

Equity also requires scrutiny at home. Departments can examine who fails to attend, who repeatedly returns without a plan and whose symptoms are dismissed or fragmented across services. Interpretation and accessible information should be considered part of care delivery. Clinicians cannot personally remove every structural barrier, but they can make patterns visible and advocate for specific changes. The achievement is strongest when access improves for a defined group and remains improved without repeated personal intervention from a senior doctor.

The institutional conditions of a worthwhile career

An agenda of professional aspiration can become unfair if it assigns clinicians responsibility for conditions they cannot control. A doctor may value careful discussion but work in appointments too short for the case mix. A committed teacher may have no protected time. Repeatedly praising dedication while leaving these contradictions untouched turns professional values into a demand for unpaid compensation for service failures.

Research on burnout interventions supports attention to both individual and organisational approaches, while leaving uncertainty about which combinations work best in particular settings [14]. Shanafelt and Noseworthy likewise place leadership, working conditions and organisational choices within efforts to improve physician wellbeing [15]. These contributions should temper any suggestion that clinicians can achieve fulfilment simply by choosing better personal goals. Institutions determine much of the environment in which those goals are pursued.

Job plans should provide time for teaching, governance and improvement responsibilities. Clinic capacity should be considered against clinical complexity, with space for urgent problems and reliable documentation. Leaders need to acknowledge concerns, explain decisions and report what action has followed. An escalation process that produces neither acknowledgement nor resolution can erode trust even when staff continue to fulfil their duties.

The quadruple aim explicitly includes the working life of healthcare staff within the pursuit of better care [16]. More recent observational evidence links perceived organisational support with professional fulfilment and lower odds of burnout, although such associations do not prove causation [17]. These findings strengthen the case for institutional accountability. Departments should be judged partly by whether clinicians can practise to reasonable standards within the resources and authority provided. A professional legacy belongs as much to leaders who create those conditions as to individuals who achieve distinction within them.

Preserving a life beyond clinical work

Medicine can provide purpose, intellectual companionship and a sense of belonging. It can also occupy every available space if boundaries are deferred until work becomes less demanding. For many clinicians, that quieter period never arrives. A considered career agenda should therefore include what the person wishes to preserve while still practising: health, close relationships, spiritual commitments where relevant, and interests that do not depend on professional recognition.

This is a matter of personal value as well as occupational sustainability. Family members and friends should not be understood merely as resources that enable the doctor to continue working. They have claims on attention and reciprocity in their own right. Nor does a clinician need to justify recreation by proving that it improves clinical performance. A worthwhile life includes experiences whose value is independent of the hospital.

Boundaries must nevertheless be compatible with responsibility. Planned leave requires appropriate cover and handover. Seeking help for illness or exhaustion may require changes to duties rather than a private determination to persevere. Institutions should make these arrangements feasible and avoid treating reduced hours or a different career pace as evidence of diminished commitment. Clinicians with caring responsibilities should not have to choose between invisibility and unsustainable availability.

Remaining capable of enjoying life while carrying serious professional obligations can itself require difficult choices. That may involve declining an appointment, relinquishing an administrative role or accepting that some opportunities are not worth their personal cost. A career cannot be assessed fairly by adding achievements while ignoring what their pursuit has displaced. Fulfilment requires an account of what was protected as well as what was accomplished.

Preparing for departure and continued purpose

Retirement gives professional legacy a practical test. Patients need continuity, colleagues need clarity and the departing clinician needs a future that is more substantial than the absence of work. Planning should begin while there is time to make choices. Abrupt departure is sometimes unavoidable; services should nevertheless prepare for foreseeable transitions.

Silver and colleagues' systematic review describes financial, occupational and personal influences on physician retirement and discusses ways organisations might support transition [18]. The review supports planning that extends beyond the date of retirement. Financial readiness matters, but so do professional identity, health, relationships and the possibility of continuing valued activities through teaching or mentoring. These options should be available without making continued contribution an obligation.

In clinical terms, transition requires more than transferring an appointment list. Outstanding investigations, surveillance arrangements and unresolved decisions need identifiable ownership. Women should know whom to contact and how ongoing care will proceed. Successors need access to the reasoning behind difficult plans without being bound indefinitely to their predecessor's preferences. A thoughtful handover protects continuity while allowing fresh clinical judgement.

Departure also requires willingness to relinquish authority. The experienced clinician may retain useful knowledge while no longer making final decisions. Institutions should offer respectful ways to contribute without creating parallel lines of command. Personal records of a career can preserve lessons, but identifiable patient material requires appropriate confidentiality safeguards. The strongest legacy may be visible in colleagues who no longer need supervision and services that continue to improve. Leaving at a chosen time, with responsibilities transferred and a life to enter, is itself a legitimate professional accomplishment.

Different careers and changing ambitions

Professional aspirations should change as knowledge, responsibility and personal circumstances change. During training, the most meaningful goals may be reliable assessment, competent emergency action and learning to seek help early. A trainee should not feel obliged to assemble an exceptional portfolio before acquiring these foundations. Exposure to different areas of practice can help identify a field in which sustained interest and service need coincide. It should also leave room to reconsider an early choice without interpreting the change as failure.

For a newly appointed specialist, the immediate challenge may be establishing sound routines within greater independence. This period offers an opportunity to identify gaps in supervision, develop trusted peer relationships and understand the institution's capacity. Ambition should allow time to consolidate practice. Accepting every committee, teaching request and additional clinic may produce visibility while leaving little attention for the clinical decisions that now carry greater personal responsibility. Choosing a manageable contribution and completing it well can provide a firmer basis for later influence.

Midcareer often brings competing claims. Clinical demand, family responsibilities, research and leadership can each expand without a corresponding increase in time. The appropriate question may shift from what can be added to what should receive priority. Some clinicians will deepen a subspecialist practice; others will improve general services or invest in education. Neither route is inherently more worthy. A generalist who offers consistent, accessible care and recognises when referral is required can leave an extensive contribution without establishing a separate specialist identity.

Later practice may offer particular scope for mentoring, difficult consultations and institutional memory, provided these roles match current competence and preference. Experience should be available without giving seniority an automatic veto over change. Equally, organisations should avoid assuming that every older clinician wishes to exchange clinical work for administration or teaching. Career discussions should establish interests, capability and realistic support. Changes in scope should be handled openly and fairly rather than through insinuation about age or the expectation of uninterrupted performance.

Different fields also offer different forms of fulfilment. In reproductive medicine, it may involve helping people understand the limits of treatment and make a considered decision about stopping. In gynaecological oncology, it may include conversations that preserve choice when cure is no longer possible. Preventive care can produce benefits that remain difficult to attribute to an individual consultation. These examples widen the idea of achievement beyond the successful intervention. They also recognise the professional skill involved in accompanying uncertainty, providing continuity and making room for disappointment without withdrawing attention. A career agenda should accommodate this work even when its value resists simple counting.

Turning reflection into a practical career agenda

Career reflection should help clinicians make choices without becoming another administrative obligation. A clinician might choose a small number of ambitions for the next stage of practice and describe the benefit each is intended to produce. One may concern clinical competence, another a recurring service problem, and another personal life. The number matters less than the clarity of purpose and the resources required.

Each ambition should answer four questions. Who should benefit? What needs to change? What support or authority is necessary? How will progress be recognised? Establishing a pain service, for example, requires more than additional clinic sessions. It may require referral agreement, multidisciplinary input and follow-up arrangements. Evidence of progress could include timely assessment and women's reports of function, interpreted alongside case mix and limitations in the data.

Reflection should also consider what to stop. An ineffective meeting, an unnecessary review appointment or a role that duplicates another person's work may consume capacity that could serve a more useful purpose. Letting go can be difficult when professional standing has become attached to being continuously needed. A mature career agenda allows contribution to change and accepts that some ambitions will appropriately be abandoned.

This proposed approach to career reflection has not been formally evaluated. Its usefulness should be explored with clinicians at different career stages and with women who use their services. Evaluation should distinguish personal satisfaction from patient benefit and examine unintended consequences, including additional workload or unequal access to opportunities. It should not become a compulsory score of professional worth. Its purpose is to help clinicians and institutions make thoughtful choices about a finite working life, while recognising that excellent careers take different forms.

Conclusion

A lasting career in obstetrics and gynaecology is built through clinical judgement, respect for women's choices and contributions that make others more capable. Its achievements include successful treatment and emergency care, but also reliable services, honest scholarship, supported colleagues and carefully prepared succession. Recognition can accompany these contributions; it should not determine their value.

Professional ambition remains necessary. The task is to give it a purpose that women and colleagues can recognise, and to provide institutional conditions in which it can be pursued responsibly. The clinician should also be able to leave practice with health, relationships and interests that have received attention along the way. The most persuasive legacy is better care, carried forward by people and services prepared to continue the work.

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