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Narrative Review

Clinical Leadership in Obstetrics and Gynaecology: A Poisoned Chalice?

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Abstract

Appointment to clinical leadership in obstetrics and gynaecology brings professional recognition, but the authority and resources of the post may fall short of its responsibilities. Leaders must reconcile urgent clinical demands, reproductive autonomy, professional disagreement, workforce shortages and financial constraints. This critical narrative review examines how those pressures are experienced across health systems and when leadership becomes a poisoned chalice. Selected primary studies, maternity investigations and international workforce reports inform an appraisal of leadership perceptions, effectiveness and limitations. Investigations in England show how established governance arrangements can coexist with failures to listen and learn. Trials in India and African countries demonstrate that better adherence to care processes does not invariably improve clinical outcomes, although coordinated clinical interventions can achieve substantial benefit. These studies do not establish the superiority of any leadership style. Hierarchical, transformational, transactional, distributed, compassionate and adaptive approaches are examined in relation to their practical contributions and characteristic weaknesses. Particular attention is paid to gynaecology, unequal access to authority, responses to safety concerns and the uncertain relationship between reputation and performance. The article's principal proposal is a reciprocal leadership compact, linking the leader's accountability for conduct and decisions with the organisation's obligation to provide authority, protected time, reliable information and timely responses to escalated risk. Leadership should be judged through patient experience, equitable access, working conditions and sustained clinical improvement. Its value ultimately depends on whether women and families receive dependable care when services come under pressure.

Keywords: *Clinical Leadership; Obstetrics; Gynaecology; Governance; Accountability; Patient Safety; Organisational Culture; Health Equity*

Introduction

An invitation to lead a department recognises experience, judgement and the confidence of colleagues. It is usually received as an honour. The unresolved complaints, vacant posts, unreliable referral arrangements and strained relationships that accompany the appointment may receive less attention. A new leader can acquire responsibility immediately while still negotiating the authority and resources needed to discharge it. If harm occurs during that interval, those distinctions offer little comfort to patients or protection to the post holder.

Obstetrics and gynaecology brings these tensions into sharp focus. An emergency may require a decision within minutes, although the staffing, facilities and working relationships on which that decision depends have developed over years. One department may oversee childbirth, early pregnancy, infertility, cancer pathways, pelvic floor disorders and complex surgery. Women may need urgent intervention or time for careful discussion, often while experiencing pain, bereavement or anxiety about intimate and consequential choices. Leaders must accommodate these needs without allowing the most visible emergencies to determine every service priority.

The metaphor of a poisoned chalice suggests an honour whose costs become apparent only after it has been accepted. It deserves examination rather than uncritical endorsement. Some leaders inherit conditions in which failure is difficult to avert. Others make those conditions worse through intimidation, favouritism, evasion or misplaced confidence. Understanding the burdens of leadership does not lessen the obligation to account for its failures. Women and families should not bear the consequences of an organisation's inability to govern itself.

Leadership becomes hazardous when the obligations of a post consistently exceed the authority and resources available to fulfil them. This article examines that predicament across health systems, considering how leadership is perceived, how its effectiveness should be judged and where established approaches fall short. We propose a reciprocal leadership compact that makes the obligations of clinical leaders and their organisations explicit, providing a practical basis for appointment, escalation and review.

The reciprocal leadership compact

The compact would match responsibility for care with the authority and resources needed to provide it. Clinical leaders would undertake to make defensible decisions, disclose significant risks, treat colleagues fairly and act within their remit. The organisation would commit to agreed resources and support, identify who can resolve matters beyond departmental control and respond to escalated concerns. Both parties would remain accountable for their contribution to the care of women and families.

The purpose is to bring these obligations into one agreement and review them together. Existing arrangements often address only part of the relationship. A risk register records hazards and a job description assigns duties, but neither necessarily establishes what the organisation must do when a clinical leader cannot remedy a hazard. The compact would record the condition of the service at appointment, the decisions delegated to the leader and the route to executive action. Subsequent review would examine whether agreed actions improved care. The effectiveness of this proposed arrangement remains to be tested.

The agreement should be recorded at appointment and reconsidered when service demands or resources change substantially. It should name the clinical and executive parties, identify unresolved risks and specify the authority, support and review arrangements attached to the role. The implementation section describes how these commitments could work in practice.

Scope and critical approach

This critical narrative review draws on targeted searches of indexed primary research and official publications. Search concepts included clinical leadership, maternity governance, obstetrics and gynaecology, professional hierarchy, workforce, mistreatment, burnout, teamwork and implementation. Sources were selected to examine how leadership operates, the outcomes associated with it and differences between settings. The review was not systematic: screening was not exhaustive, no protocol was registered prospectively and no pooled estimate of leadership effectiveness was calculated.

These sources answer different questions. Inquiries expose serious governance failures but do not establish how common those failures are across services. Workforce reports describe the conditions in which leaders work. Cross-sectional surveys identify associations, and clinical trials evaluate interventions whose effects may depend partly on leadership without measuring its separate contribution. The organisational arrangements proposed here follow from a critical reading of this evidence; they have not themselves been validated.

Geographical comparisons also require care. Public and private institutions within the same country may differ more than teaching hospitals on different continents. National income reveals little about the distribution of services, political accountability or access to emergency care. Reliance on English-language publications makes some systems more visible than others. These limitations should temper any claim to describe leadership worldwide.

What leadership means, and to whom

Clinical leadership encompasses formal office and the influence exercised in everyday work. A clinical chair may set departmental priorities, while a labour ward coordinator directs important decisions during a shift. A senior registrar's response to uncertainty may determine whether a junior colleague asks for help. Executives, nursing and midwifery leaders, anaesthetists, service managers and community clinicians also shape the conditions in which obstetricians and gynaecologists practise. Their responsibilities intersect, but each should remain sufficiently clear for decisions and omissions to be examined.

Leadership is experienced differently across a service. For a woman awaiting care, it may be evident when someone explains a delay, arranges an interpreter or takes a persistent symptom seriously. Trainees may judge the fairness of supervision and access to operating lists. Consultants may value professional autonomy, equitable workloads and fair procedures, while executives may emphasise expenditure, activity and regulatory assurance. These perspectives offer a basis for appraisal, although they have not been established by a single international survey. Each reveals only part of the role.

Popularity is an uncertain measure of effectiveness. Avoiding difficult conversations can preserve collegial approval while allowing unsafe practice to continue. Conversely, a necessary restriction on activity may attract criticism despite protecting patients. Patient satisfaction also needs interpretation: courtesy is essential, but a pleasant consultation does not establish diagnostic accuracy, just as a technically appropriate decision does not excuse dismissive communication. Leadership assessment should seek agreement between different sources of evidence rather than treating approval from one constituency as decisive.

Professional status can distort these judgements. Operative skill, academic reputation and seniority may confer credibility without demonstrating competence in resolving conflict, planning a workforce or investigating concerns fairly. Equally, familiarity with management does not confer clinical expertise. Those appointed to lead need sufficient understanding of the service to recognise uncertainty, seek appropriate advice and make defensible decisions.

A worldwide appraisal: Different systems, recurring tensions

Access to clinically indicated care provides a useful starting point for international comparison. Boerma and colleagues analysed data from 169 countries and found large differences in caesarean use between regions, wealth groups and public and private facilities. Their estimates concern 2015 and should not be interpreted as current national performance measures. They show, however, that limited access and possible overuse can coexist within and across health systems. Aggregate procedure rates cannot establish whether individual decisions were appropriate or whether a particular leadership culture was effective. Leaders need to examine who receives indicated treatment, who cannot obtain it and where unnecessary intervention may occur [1].

Publicly funded services and the limits of formal assurance

The English maternity investigations warn against assuming that established governance arrangements ensure reliable care. The Ockenden review of Shrewsbury and Telford described failures to investigate, learn and engage properly with families. Its findings show how formal assurance can continue even when an organisation fails to recognise the significance of its own evidence [2].

The independent East Kent investigation also examined institutional responses, professional relationships and the handling of concerns [3]. Neither investigation provides a representative account of UK maternity care. Both, however, expose ways in which established

services can become resistant to correction. Repeated external scrutiny is of limited value if its findings do not alter everyday decisions and practice.

The Care Quality Commission's national review of maternity services in England reported substantial variation in leadership, including approachable teams as well as vacancies, weak oversight and inadequate responses to concerns [4]. Governance is best judged by the response to information. A committee, risk register or safety champion can support improvement, but its existence does not establish that a dangerous condition has been corrected.

For clinical leaders in publicly funded systems, demand and capacity may be determined beyond the department. Nevertheless, constraints do not eliminate the duty to prioritise fairly, identify unsafe arrangements and communicate their consequences. The corresponding duty of executives is to decide explicitly what will be funded, changed or restricted. Responsibility for an unresolved risk should not fall indefinitely on the clinician who brought it to attention.

Insurance-based, mixed and private systems

In insurance-based and mixed systems, leadership appraisal should examine the relationship between clinical judgement, reimbursement and access. Possible conflicts include pressure to maintain profitable procedures, fragmented responsibility across providers, and exclusion of patients whose care is financially unattractive. These are governance risks to investigate in the relevant institution, rather than universal descriptions of private care. Public providers can also reward volume and shift costly work elsewhere.

Survey research from India illustrates the need for such scrutiny. Bhatia and colleagues found higher caesarean use in private facilities after adjusting for observed characteristics, and interpreted the remaining difference as consistent with provider-induced demand. Unmeasured clinical differences and selection into facilities limit that explanation. The findings warrant examination of payment incentives and surgical indications, but cannot establish that a particular operation was unnecessary or that leadership in private services is uniformly inferior [5].

Private ownership may permit rapid investment and operational flexibility. It may also concentrate authority and make independent challenge difficult where commercial and clinical decisions overlap. Appraisal should establish whether the organisation discloses competing interests, protects clinical advice and monitors outcomes beyond billable activity. A well-equipped theatre does not establish equitable referral, continuity after complications or informed choice.

The same scrutiny applies to public-private partnerships and referral networks. The leader of a receiving unit may appear responsible for deteriorating outcomes while lacking authority over the referring facility's staffing, transport or diagnostic delays. Contracts and partnership agreements should allocate those obligations before a crisis exposes their absence. Responsibility for the pathway extends beyond the institution issuing the final discharge summary.

Resource-constrained services and the danger of romanticising resilience

Where blood, transport, theatre access or essential staff are unreliable, individual ingenuity can save lives. Celebrating exceptional effort, however, may conceal dependence on repeated personal sacrifice. The State of the World's Midwifery 2021 documented a substantial global workforce shortfall and called for investment in education, working conditions, leadership and governance. Its estimates describe the period covered by the report, but underline how strongly clinical care depends on the workforce available to provide it [6].

Leadership in such circumstances should be judged partly by improvements in referral reliability, supply systems and team capability, rather than by unadjusted mortality alone. A referral hospital accepting the sickest women may have worse crude outcomes than a facility transferring complications elsewhere. Comparisons require information about case severity, transfer delays and the populations excluded from care. Otherwise, apparent success can reward avoidance of difficult patients.

The QUARITE cluster-randomised trial in Senegal and Mali demonstrates the potential of organised improvement in referral services with limited resources. Maternal death review, educational outreach and emergency obstetric training reduced hospital-based maternal mortality overall. Benefit varied by hospital type, however, and was not demonstrated in regional hospitals outside the capitals. The findings support linking review to practical changes in care, with attention to the circumstances in which the intervention is used. They do not establish the separate contribution of a leadership style [7].

Scarcity does not excuse abusive conduct, discriminatory triage or concealment. It does, however, change what a reasonable improvement plan can demand. A recommendation to increase consultant presence is incomplete without a feasible workforce, training and financing strategy. External advisers should distinguish immediate achievable changes from requirements needing national investment, while local leaders should document the risks that cannot safely be absorbed.

Centralised systems, migration and political constraints

Centralised governance can coordinate investment and establish common standards, although it may leave local leaders little discretion. Its effectiveness depends partly on whether unwelcome information reaches decision makers without being softened or withheld. Decentralisation may allow more local initiative while leaving gaps between organisations. Either arrangement requires clear responsibility for ensuring that a woman needing urgent care reaches a team able to provide it.

Services with multinational workforces should examine whether insecure contracts, language differences or unequal recognition of experience restrict participation. The GMC-commissioned Fair to refer? study identified inadequate induction, isolated roles, inaccessible leadership and a tendency to assign blame among factors contributing to disproportionate employer referrals in the UK. These qualitative findings describe possible organisational mechanisms rather than a universal migrant experience [8]. Feedback, support and routes for raising concerns should be accessible to temporary, locally employed and internationally recruited colleagues as well as established staff. Similar mechanisms elsewhere would need to be investigated locally.

Conflict, political interference and unstable financing impose further limits. Interpersonal skill cannot restore a destroyed referral network or secure an interrupted supply chain. Leaders can nevertheless be candid about service limitations, allocate available care fairly and seek to protect staff. Appraisal of their performance must take account of these political and material circumstances.

Leadership styles: Contributions and characteristic flaws

Leadership terminology describes approaches that often overlap in practice. The same clinician may need to direct an emergency, negotiate a service change and support a colleague in distress. The studies considered here do not permit these approaches to be ranked reliably by maternal or gynaecological outcomes. Table 1 sets out their practical uses, limitations and safeguards as a critical interpretation of the literature.

Directive leadership is necessary when an emergency requires clear coordination. Someone must allocate tasks, recognise deterioration and decide when to escalate. Its flaw appears when temporary command becomes a permanent claim to unquestionable authority. Clear command must leave room for a colleague to identify an error or question a decision. Asking for challenge does not transfer the decision away from the responsible clinician.

Transformational leadership can help a department move beyond routine activity towards a shared purpose. It becomes less useful when ambition and personality substitute for agreed responsibilities, resources and measures of progress. A compelling vision for safer childbirth is of little practical value if staff cannot obtain help at night. Charisma may also discourage criticism when disagreement is interpreted as disloyalty to the reforming leader.

Transactional leadership makes expectations explicit through standards, feedback and consequences. It can support dependable rostering, documentation and routine processes. Difficulties arise when measurable tasks draw attention away from less visible needs. A department rewarded for throughput may record more activity while shortening consultations or passing unresolved problems elsewhere. Targets therefore need accompanying measures that reveal these effects.

Distributed leadership draws on expertise across professions and grades, bringing decisions closer to those doing the work. It can also leave responsibility unclear when many people participate but none can authorise action or answer for delay. Shared leadership requires agreed boundaries, named decision makers and a timely means of resolving disagreement. Those accepting responsibility should have a corresponding share of authority.

Compassionate leadership requires attention to distress and a practical response to the circumstances causing it. Listening sessions without changes to unsafe workloads can increase disillusionment. Compassion also includes protecting patients and colleagues from persistent misconduct, using a fair process. Colleagues and patients are poorly served when compassion is invoked to avoid difficult decisions.

Adaptive leadership encourages enquiry when problems have no simple technical solution. It is valuable for redesigning pathways and negotiating competing needs, but continual experimentation can become an excuse for failing to provide basic standards. Leaders need to distinguish problems requiring enquiry from failures to meet obligations that are already clear.

Approach	Useful contribution	Characteristic risk	Practical safeguard
Directive	Coordinates urgent decisions and tasks.	Emergency authority becomes routine intimidation.	Name the coordinator; invite challenge; review decisions afterwards.
Transformational	Builds commitment to service improvement.	Aspirations and personality outpace capacity.	Agree resources, stages of delivery and measures of benefit.
Transactional	Makes routine standards and duties explicit.	Targets displace less measurable patient needs.	Review outcomes and unintended effects as well as activity.
Distributed	Uses expertise across professions and grades.	Shared participation obscures who can decide.	Specify decision rights and a route for resolving disputes.
Compassionate	Responds to distress and supports fair treatment.	Listening replaces action or difficult decisions.	Link concerns to practical support and fair accountability.
Adaptive	Supports enquiry and redesign where solutions are uncertain.	Experimentation delays established standards of care.	Separate questions needing enquiry from duties requiring action.

Table 1: *Leadership approaches in obstetrics and gynaecology.*

Table 1 is an author-developed conceptual comparison informed by the discussion. It does not imply that the approaches are mutually exclusive or have been ranked by clinical effectiveness. Evidence on supervisory behaviour, inclusion and team conduct is discussed below [9-11].

Does leadership improve outcomes? What the evidence permits

Leadership is difficult to isolate experimentally. Recruitment, funding, staffing, institutional history and patient complexity affect both perceived leadership quality and outcomes. A successful department may rate its leader favourably because conditions are good; an able leader appointed to rescue a failing service may receive poor ratings before change becomes possible. Causal claims therefore require restraint.

In a large US healthcare organisation, Shanafelt and colleagues found an association between physicians' ratings of their supervisors and physician burnout and satisfaction [9]. The study supports attention to everyday supervisory behaviour, but it does not establish that changing leadership style alone improves patient outcomes. It's setting within one organisation and observational design limit transfer to other systems.

Nembhard and Edmondson's study of neonatal intensive care teams linked inclusive leadership, professional status, psychological safety and participation in improvement work [10]. It helps explain why colleagues' contributions matter, particularly where professional hierarchies may inhibit speaking up. The study did not measure reductions in maternal mortality. Riskin and colleagues, in a randomised neonatal simulation study, found that exposure to rudeness impaired team performance [11]. This provides experimental evidence that interpersonal conduct can affect how a team works, although the findings cannot be assumed to quantify harm in clinical practice.

Draycott and colleagues reported improved neonatal outcomes after the introduction of local obstetric emergency training [12]. Their observational comparison of outcomes before and after training supports organised preparation for emergencies, although other changes over the same period may have contributed to the improvement.

The BetterBirth cluster-randomised trial in Uttar Pradesh, India, offers an important caution. Coaching around the WHO Safe Childbirth Checklist improved adherence to selected practices without significantly improving the primary maternal and perinatal composite outcome [13]. Better compliance cannot, by itself, establish clinical benefit. The result also leaves important questions about which practices changed, the extent of change and the capacity of the wider system to provide effective care.

In E-MOTIVE, hospitals in Kenya, Nigeria, South Africa and Tanzania introduced early detection and bundled treatment of postpartum haemorrhage, supported by an implementation programme. The primary composite outcome occurred in 1.6% of intervention patients and 4.3% of those receiving usual care, with a risk ratio of 0.40 [14]. The trial demonstrates the benefit of a coordinated clinical package. Leadership may help create the conditions for its delivery, but the study did not compare leadership styles or isolate their effects.

US evidence adds a complementary example. In California, Main and colleagues compared hospitals participating in a haemorrhage quality collaborative with non-participating hospitals. Severe maternal morbidity among women with haemorrhage fell by 20.8% in collaborative hospitals and 1.2% in comparison hospitals. The intervention combined a safety bundle, shared data and nurse-physician mentoring. Its non-randomised design leaves possible selection effects and other differences between hospitals. The findings support collaborative infrastructure for improvement, while falling short of proving that any one leadership approach caused the reduction [15].

These studies support judging leadership by its contribution to dependable clinical work. Improvements should be demonstrated and sustained, with appropriate recognition of the teams and conditions that made them possible. The African trial also challenges any assumption that effective innovation must originate in wealthy health systems.

The neglected test: Leadership in gynaecology

Maternity dominates much of the public discussion of leadership, particularly after catastrophic outcomes. In gynaecology, failures may unfold less visibly through delayed assessment, interrupted follow-up, restricted access to surgery, persistent pain and repeated postponement of care. A department can respond well to obstetric emergencies while leaving these needs inadequately addressed.

Elective capacity is a clinical resource that requires deliberate protection. Cancelling gynaecological surgery may be necessary during an emergency; recurrent, predictable cancellations require a different response. Leaders should examine why operations are cancelled, how long women wait for rebooking and whether their symptoms or clinical urgency change during that interval. Completed operating lists alone provide an incomplete account of the service.

Pathway redesign must also respect diagnostic uncertainty. Moving care closer to home may improve access, but referral criteria should permit timely reassessment when symptoms persist or evolve. A rejected referral is not evidence that the woman's need has disappeared. The receiving and referring services should agree who remains responsible, how deterioration is recognised and how a disputed decision can be reviewed.

Surgical leadership requires fair allocation of complex cases, supervision and access to multidisciplinary advice. Neither operating volume nor individual reputation adequately describes quality. Outcome review should include complications, reintervention, functional recovery and patient-reported benefit, with adjustment appropriate to the case mix. Concentrating difficult surgery may improve capability while creating travel and capacity burdens that need explicit assessment.

Reproductive medicine, contraception, menopause and pelvic floor services also reveal the limitations of counting completed episodes. A woman may leave an appointment without a clear plan or access to affordable follow-up, despite the episode being recorded as complete. Leaders need oversight of the whole pathway, particularly transfers of responsibility at which follow-up can fail. These proposals require evaluation within gynaecology; findings from maternity services cannot establish their effectiveness in other areas of the specialty.

Power, professional identity and the experience of women

Obstetricians and midwives bring complementary expertise to maternity care. When professional loyalties become territorial, disagreement can shift towards ownership of care and away from the needs of the woman concerned. Shared clinical goals, respectful discussion and clear responsibility for action are needed to keep those needs central.

Women must also be able to question the plan. The WHO quality framework places experience of care alongside provision of care, making communication, dignity and support integral to quality rather than optional additions [16]. Leaders should examine whether these principles survive busy shifts, language barriers and unexpected complications. The person requesting clarification should not have to overcome the collective defensiveness of the team.

Bohren and colleagues' multicountry study documented mistreatment during facility-based childbirth in Ghana, Guinea, Myanmar and Nigeria [17]. It shows why institutional success cannot be assessed solely through survival or procedural capability. The findings concern the participating settings and should not be used to stereotype entire national systems. They support direct enquiry into consent, discrimination and treatment experienced by women, including those least able to complain.

Patient involvement in governance should reach beyond those already comfortable speaking in formal meetings. Services need to consider who cannot attend, whose language is unrepresented and whether participants hear what happened to their recommendations. Confidential routes are important where women fear that criticism could affect continuing care. Participation should influence priorities and review while respecting privacy and the responsibilities of clinical judgement.

Leadership opportunities within the workforce deserve similar scrutiny. Access to committees, acting roles, mentorship and protected development time may shape future appointments long before an interview occurs. Transparent criteria and review of progression by relevant staff groups can reveal inequities that a nominally open competition misses. Fair access to opportunity and authority gives substance to a stated commitment to inclusion.

How the chalice becomes poisoned

Responsibility without sufficient control is one source of harm. A leader may be expected to ensure safe staffing without authority to recruit, or to reduce waiting times without additional clinic or theatre capacity. A written account of the role should identify these dependencies and the decisions reserved to more senior management. Otherwise, the post holder may be judged against commitments that cannot be fulfilled through their own decisions.

Unresolved risk can gradually become accepted as routine. Repeated requests for a senior clinician to provide extra cover may avert immediate harm while concealing an unsustainable staffing arrangement. When such assistance becomes indispensable to everyday care, the service is relying on goodwill to meet a continuing obligation. Leaders need to make that dependence visible and distinguish emergency assistance from a durable staffing solution.

Institutional defensiveness compounds the difficulty. Warnings may be acknowledged formally but reframed as communication difficulties, isolated dissatisfaction or insufficient resilience. A concern should be examined on its merits even when the person raising it is distressed or difficult. Equally, an allegation requires fair investigation rather than automatic acceptance. The organisation must protect both the right to raise concerns and the right to an evidence-based response.

Assurance can itself become misleading. Better reporting may initially reveal more incidents, making an improving service appear worse. Low reporting may look reassuring while reflecting fear or futility. Leaders and boards should interpret reporting alongside severity, independent review, patient accounts and the completion of corrective action. Reporting should produce a trustworthy account of care, even when that account is uncomfortable.

The personal cost also deserves attention. A UK survey found burnout among a substantial proportion of obstetricians and gynaecologists, associated with defensive practice and poorer wellbeing [18]. It did not establish prevalence among clinical leaders specifically. Even so, an appointment that routinely demands unlimited availability is difficult to sustain. Protected time, dependable deputy cover and confidential support should form part of the role, with working arrangements that allow sufficient rest and attention to clinical and organisational decisions.

Leaders can also make the role destructive through their own conduct. Favouring allies, withholding information, humiliating colleagues or treating disagreement as insubordination damages the capacity to learn. A leader's account of being obstructed should be tested as carefully as an institution's account of being well led. Independent review protects against both scapegoating and self-exoneration.

Putting the reciprocal compact into practice

Element	Clinical leader's undertaking	Organisation's undertaking and review record
Starting position	Disclose known concerns and agree realistic priorities.	Record inherited risks, capacity, resources and decisions already pending.
Authority and support	Use delegated powers fairly; identify dependencies.	Specify decision rights, protected time, deputy cover and analytical support.
Escalation	Describe the hazard, urgency and immediate safeguards.	Name the decision maker and response deadline; record the decision and reasons.
Delivery and follow-up	Implement agreed actions and report residual risk.	Provide agreed support; check completion and effects on patients and staff.
Review and succession	Accept feedback, independent review and orderly handover.	Review reciprocal performance, unresolved concerns and continuity arrangements.

Table 2: *Proposed operational elements of the reciprocal leadership compact.*

The framework in table 2 is intended for local adaptation. Its feasibility, effectiveness and unintended consequences require evaluation.

An appointment should begin with an honest account of the service: unresolved risks, staffing and capacity, complaints, current investigations, financial constraints and the limits of delegated authority. The incoming leader should be able to agree priorities, realistic expectations and the resources needed to address them. Selection should examine judgement, fairness and conduct alongside professional distinction.

Review would consider the conduct of both parties. The clinical leader should provide candid information, make defensible decisions, involve appropriate expertise and act on matters within their control. The organisation should provide protected time, administrative and analytical support, access to decision makers and a documented response when a concern exceeds departmental authority. Reviewing these obligations together would make it easier to identify where action had stalled and who was responsible for the next decision.

Escalation should lead to a decision and a response. Each serious concern needs a clear account of the hazard, its urgency, immediate safeguards, a named recipient and a deadline proportionate to the risk. The response should specify action, further investigation or the reasons for a decision about the risk that remains. Recording a concern does not discharge the duty to respond, and formal acceptance of a risk does not settle whether the arrangement is ethically defensible. WHO and UNICEF guidance on maternal and perinatal death surveillance and response also links review to action, advocating confidentiality and learning alongside accountability for results. These principles inform the compact, although the guidance does not validate the proposed agreement [19].

Shared leadership should have an explicit decision structure. Obstetric, gynaecological, midwifery, nursing, anaesthetic and operational expertise should be available where relevant, without making every decision dependent on universal agreement. Disputes need a timely route to resolution. Staff should know who directs an emergency, who can change capacity and who is responsible for following up a delayed investigation.

Improvement should concentrate initially on a few clinical problems that matter to the service, such as delayed recognition of haemorrhage, repeated elective cancellations or loss to follow-up after abnormal results. The department should agree the intended change, establish its starting position and identify the resources and measures needed to judge benefit and harm. Training should support changes in practice, with review continuing after intensive implementation support ends. Where gynaecological surgery is repeatedly cancelled because emergency demand occupies the theatres, for example, the clinical lead would document the pattern and its consequences. The executive counterpart would decide whether to protect capacity, change scheduling or commission another pathway. Subsequent review would examine cancellations, time to rebooking, delays in emergency care and patient experience. The agreement would be useful only if it helped secure and assess these changes.

The compact also requires independent review and provision for succession. Feedback from women and staff should inform appraisal of leaders, with protection against retaliation and safeguards against misuse. Deputy arrangements and orderly handover reduce dependence on a single individual. A service that becomes unreliable whenever its leader is absent remains organisationally vulnerable.

Measuring effectiveness without rewarding appearances

Assessment should bring together clinical outcomes, care processes, patient experience, equity and the organisation's response to concerns. No single score adequately represents them all. Outcome comparisons need valid denominators, appropriate adjustment for case mix and sufficient observation to distinguish a meaningful change from ordinary variation. Rare events require individual review as well as aggregate analysis. Missing data and differences in referral patterns should be made explicit.

Process measures should remain linked to plausible clinical benefit. Completion of a form or attendance at a meeting demonstrates activity, not necessarily improved care. Measures of referral completion, timely response to deterioration and delivery of indicated treatment are closer to the clinical purpose, although they too require reliable collection. BetterBirth is a reminder that even meaningful process gains may not produce the anticipated outcome [13].

Patient experience should include consent, explanations, dignity, continuity and the handling of complaints. Workforce assessment should consider supervision, workload fairness, turnover and the perceived consequences of speaking up. Equity requires examining whether performance differs across relevant populations rather than assuming an acceptable average represents everyone. These domains are proposed for local adaptation, not offered as a validated composite index.

The speed and quality of an organisation's response to concerns are further measures of effectiveness. Review should establish how long serious concerns await a decision, whether corrective actions are completed and checked, and whether successive complaints describe the same unresolved problem. Boards should examine their own contribution, including delays in funding, recruitment and service decisions.

Research priorities and limitations

Research should distinguish leadership training from behaviour in practice and from the authority available to the role. Prospective comparisons could examine whether clearly delegated powers and agreed escalation arrangements improve the response to concerns, staff retention and patient outcomes. Controlled implementation studies may be feasible, although staff movement, changes in personnel and differences between services would complicate interpretation. Evaluation of the compact should assess the time from a serious concern to a decision, the action taken and its effects on care. It should also examine possible harms, including administrative burden, defensive documentation and the transfer of accountability without corresponding authority.

International research needs greater representation from under-resourced and politically constrained services, with local ownership of questions and interpretation. Gynaecological leadership requires dedicated investigation rather than continued dependence on maternity evidence. Studies should include women who disengage from care and staff who leave institutions, since surveys confined to current participants can miss those most harmed by existing arrangements.

This review is limited by selective retrieval, reliance on English-language sources and the use of primary studies alongside official investigations and ethical argument. Much of the evidence does not isolate leadership, and several proposed mechanisms have not been adequately tested across countries. It cannot support causal claims about national leadership cultures or establish a universally preferable style. It does provide grounds for examining more closely how authority is exercised, decisions are reviewed and warnings are answered.

Conclusion

Clinical leadership in obstetrics and gynaecology becomes a poisoned chalice when an appointment confers obligations that the holder has little means of fulfilling. The danger increases when reassurance replaces enquiry and repeated personal sacrifice allows an inadequate service to continue. Yet institutional constraints cannot account for every failure. Leaders remain responsible for the power they exercise, the concerns they hear and the decisions within their control.

Organisations should give clinical leaders the authority, time and support needed to act, and respond candidly when a service cannot meet its obligations. Leaders should accept fair scrutiny of their judgement and conduct. For women and families, the value of these arrangements lies in accessible, respectful and dependable care across maternity and gynaecology. Whether that care remains possible under pressure is a more exacting measure of leadership than title, reputation or institutional approval. The reciprocal compact provides a proposed means of recording these expectations and examining whether both parties fulfil them.

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Ethics

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Data Availability

No original dataset was generated or analysed.

Author Contributions

O Amu: Conception and literature review. All other authors: Literature and manuscript review.

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