JNTP Vol.1 No.2 (March 2026) 001002a626

Journal of Nursing Theory and Practice

journal homepage: https://pops.uclan.ac.uk/index.php/jtnp

Editorial

Exploring a culture of injustice in NHS maternity services: A Rawlsian perspective

Paul Regan [a], Elaine Ball [b]

[a] School of Nursing and Midwifery, University of Lancashire; [b] Senior Lecturer in Adult Nursing, Programme Lead, Professional Doctorate, School of Nursing, Midwifery and Social Work, University of Salford.

Editorial note: *Editorials are opinion pieces. This editorial has not been subject to peer review and the content expressed are those of the authors.*

Introduction

Since the first National Health Service (NHS) inquiry into failing care at Ely Hospital in 1969, more than 120 inquiries have examined recurring failures in the service. Yet, over a decade after the Francis Report (2013) and its 290 recommendations, progress on culture and professional behaviour remains limited. The national responses, Compassion in Practice (DH, 2012) and the NHS Constitution (2025), initiated in 2015, sought to re-centre care around values of compassion, competence, communication, courage and commitment. The NHS Constitution reinforced an NHS for all—offering a comprehensive service available to all, delivering high-standards of professionalism and excellence, access based on clinical need rather than ability to pay and working across organisational barriers. The Constitution promoted patients placed at the heart of the NHS, providing best value for taxpayers' money, and maintaining accountability to the public, patients, and communities. Nonetheless, avoidable harm persists.

This paper examines recommendations from critical inquiries of the NHS in relation to maternity services (Darzi, 2024; Kirkup, 2015; 2022; MBRRACE-UK, 2025) that impact on nursing, midwifery and patients. These reports focus specifically on maternity services, which serve one of the most vulnerable patient populations: mothers and babies. Two issues are intimately connected: (1) cultures and professional behaviours increasingly shaped by business-oriented logics, and (2) the corresponding objectification of patients, resulting in moral harm and injustice (Martin et al., 2024; Regan & Ball, 2017). We connect evidence from recent maternity inquiries to a normative framework grounded in Rawls's theory of justice, showing how institutional arrangements can either protect or undermine fairness, respect and moral responsibility in healthcare (Goodair et al., 2024).

Kirkup reports

The Morecambe Bay Inquiry (Kirkup, 2015) reported a dysfunctional midwifery service that failed to provide safe and effective care; with insufficient clinical competence of midwives, paediatricians and obstetricians unable to identify warning signs in pregnancy, labour and newborn babies. Poor working relationships between different professional groups led to sub-optimal care, poor record keeping and handing over critical information in a timely manner. Of concern due to its impact on relationship building and sharing information, was poorly attended multi-disciplinary team meetings (Kirkup, 2015). During the investigative period, from a rigorous search of case reports, 233 cases were serious untoward incidents, with sixty-three pregnancies requiring a comprehensive review.

From a financial perspective, the Chief Executive spoke about the difficulties of maintaining safe practice due to £24 million cost savings, reduced management and the cost of negligence claims. Kirkup also identified that the National Tariff, now called the NHS payment scheme, (NHSE, 2026), did not cover the cost of the maternity services, leaving a £5.4 million funding gap. The NHS payment scheme is a set of rules, prices, and guidance to determine how much healthcare providers are paid for the commissioned services they provide (NHSE, 2026). This led to future risk of recruiting adequate numbers of obstetricians and midwives (Kirkup, 2015).

Seven years later, Reading the Signals (Kirkup, 2022) identified similar failings in the East Kent Hospitals University NHS Foundation Trust maternity services. Mothers and babies were left unprotected by poor clinical behaviour, lack of compassion, denial of concerns, and failures to meet basic standards. A culture of normalised poor behaviour led to acceptance of substandard care

Corresponding author: School of Nursing and Midwifery, University of Lancashire, PR1 2HE, UK.
Email: PJRegan@lancashire.ac.uk. **© 2026 The author(s).** Published by University of Lancashire Open Journals (Hosted and supported by Open Journal Systems).
This is an open access article under the CC-BY licence (https://creativecommons.org/licenses/by/4.0/).
https://doi.org/10.17030/lancashire.jtnp.626.
Submitted 15 September 2025; **Accepted** 8 December 2025; **Published** 30 March 2026.

and a lack of positive role models. Kirkup's (2022, section 6.30) recommendations emphasised that teams who train together, work well together, should begin at undergraduate level. Trusts were found to prioritise reputation management through denial and deflection. A lack of common purpose contributed to poor teamwork, mistrust between professional groups, fragmentation of work, and inadequate support. Despite midwifery being a profession 99% dominated by women (NHS Digital, 2021), mothers reported experiences of care they perceived as neglectful or dismissive.

Recent findings confirm these issues remain widespread. A 2024 evaluation of the National Maternity Inspection Programme by the Care Quality Commission (CQC) found that almost half of inspected maternity units showed weaknesses in teamwork, communication, leadership credibility, and organisational learning—core components of safe maternity culture. This suggests the failures identified by Kirkup reflect recurring system wide vulnerabilities rather than isolated incidents.

Lord Dazi's independent report

The independent report by Lord Darzi (2024) found that maternal deaths had increased since the COVID 19 pandemic, describing the NHS as being in "serious trouble" due to poor public satisfaction and low staff morale. Darzi argued that rebuilding trust requires addressing root causes of concern and implementing clear recommendations for change. These include re engaging staff, strengthening patient voice, increasing productivity, budgets, promoting dignity, respect and compassion, and developing more integrated care closer to home. Darzi (2024) found the drive for cost efficiency increased significantly over the last two decades, unintentionally leading to £1 billion of negligence claims in maternity care between 2023-2024. The chronic lack of capital investment, cost improvement targets and need to recruit staff ensured managers were under constant pressure to balance resources (Darzi, 2024).

MBRRACE-UK Confidential Enquiry 2021–2023

The MBRRACE-UK report (Felker et al., 2025) focused on lessons learned between 2021 to 2023. Key areas related to healthcare professionals and services to develop urgent referral pathways to triage elevated risk women, improve information sharing, codify domestic abuse and safeguarding cases, improve discharge planning and summary of actions. Overall, in 2021 to 2023, n=284 women died during pregnancy or within forty-two days of the end of pregnancy. Twenty one deaths were accidental, leaving 263 attributable to direct or indirect causes. Thrombosis, thrombo-embolism, and cardiac conditions were the leading cause of death, and Covid 19, the second most common. Assessment of the n=263 cases found that 21% were judged to have received safe care and improvements in care may have altered outcomes for 45% (Felker et al., 2025). Black women were 2.3 times more likely to die and Asian women 1.3 times more likely than white women. Increased risk was exacerbated by deprivation, ethnicity, domestic abuse, drug, substance or alcohol abuse or a number of previous pregnancies.

Notably, only 2% of women who died had known pre-existing cardiac problems, highlighting a gap in screening. Sixty-six percent of women who died from indirect causes and 56% of women from coincidental causes who died during pregnancy (or up to six weeks after pregnancy), had a postmortem examination. The authors reinforced the importance of establishing the exact cause of death with a high-quality autopsy to improve future care and screen for cardiac conditions (Felker et al., 2025).

Ethnic inequalities and moral injustice

A 2024 national cohort study (Vousden et al., 2024) demonstrated that Black women remained 2.43 times more likely to die during or shortly after pregnancy than white women, even after adjustment for clinical and demographic factors. Asian women faced a 1.57 fold increased risk due to poor communication, escalation and pain dismissal. These disparities cannot be explained by known risk factors alone and instead point to systemic biases and institutional failings—directly challenging Rawls's argument that justice requires protecting the least advantaged.

Discussion

NHS organisations are large, complex systems where managerial, structural and cultural forces intersect. Inquiry after inquiry has exposed dysfunction, but meaningful cultural change has often proven elusive (Martin et al., 2023). Market logics and financial pressures have reshaped priorities, fragmenting commissioning, weakening shared purpose, and inadvertently objectifying patients (Regan & Ball, 2017). In such environments, mothers and babies—already highly vulnerable—bear the moral cost of these systemic failures (Maternity Action, 2018). Similar patterns emerge internationally, where the financialisaton of healthcare in the United States has shifted clinicians' focus away from patients and towards profit (Fuse Brown & Hall, 2024). While the NHS has not fully replicated this trajectory, its increasing exposure to commercial pressures suggest a concerning direction of travel. A cultural shift grounded in justice and compassion is required.

Justice

The Beveridge (1942) vision underpinning the NHS sought to secure citizens against avoidable harms arising from want and ill health. Today's reports of persistent failures indicate not only technical or managerial short-

comings but also moral violations—what Ricoeur (2000) describes as a form of social 'violence,' where power is exercised in ways that breach justified expectations of care. Several scholars, including Fritz and Cox (2019), emphasise the relevance of Rawlsian theory for health system design. John Rawls (1921–2002), an American political philosopher in the liberal tradition, proposed a "justice as fairness" that speaks directly to the moral responsibilities of public institutions such as NHS maternity services (See Table 1)

Rawls's theory rests upon the idea that a "just" democratic society must be organised around equal basic liberties and a basic structure that works for the benefit of the most disadvantaged members (Rawls, 1971). The NHS, founded on principles of fairness and equality, is well aligned with these commitments, yet the persistent failures across maternity services suggest deviations from the institutional integrity. Rawls (1971) suggests reversing utilitarian impulses requires reconstructing the ethos of the NHS around the legitimate use of non partisan power (Clement, 2023). Rawls reinforces a return to fairness, equity, and respect, grounded in the idea that participants remain 'mutually disinterested'—a concept often misunderstood (Eckert, 2015). Mutual disinterest, for Rawls, does not imply hostility or indifference, but rather a principled unwillingness to advance one's own goals at another's expense (Eckert, 2015). This bears striking resemblance to what occurs in maternity settings when healthcare professionals fail to work well together: where even small breaches in cooperation can directly impact the safety of mothers and babies.

Central to Rawls's model is the veil of ignorance, which asks individuals to imagine themselves designing the rules of a just institution without knowing their own position within it (Eckert, 2015). The veil deprives decision makers knowledge of characteristics that might bias their judgement—social position, occupation, ethnicity, pregnancy status, or health condition. Under this model of fairness, the NHS functions effectively only when organisational structures are untethered from reward, incentive, and political leverage (BMA, 2022). This view is particularly useful for maternity policy. The veil of ignorance offers a structured way of evaluating policies by asking a simple question: would this rule be acceptable if we did not know whether we were a senior clinician, an overstretched midwife, a first time mother, someone with limited health literacy, or a baby whose welfare depends entirely on others?

Rawls's theory encourages the imaginative work of stepping back from current arrangements to reconsider what a just maternity service would require. This involves confronting known failures and reconstructing systems from a position of fairness (Davies, 2019). Two factors are especially relevant from Rawls's account when developing a just maternity service. First, the integrity of the system: structures must promote moral responsibility, ensure compliance with professional codes, and prevent harm. Second, the principle of impartial decision making: the veil of ignorance directs organisations to ensure that the greatest benefit is delivered to the least advantaged—women and babies—whose vulnerabilities place them most at risk within healthcare systems (Davies, 2019). A Rawlsian approach, therefore, insists that maternity services do more than correct clinical deficiencies; they must embed fairness into organisational culture, decision making processes, and accountability mechanisms (CQC, 2024). Only then can the NHS uphold its foundational commitment to justice.

Rawlsian justice: From principle to practice in maternity care

The veil of ignorance as a governance test in maternity services, links to the principle of equal basic liberties (EBL) and translates into the secure right to safe, respectful, well-informed, and participatory care. For maternity services, this implies: a zero tolerance for any degrading experience, delay, or denial of fundamental care and support (e.g., postnatal pain relief). Unreliable com-

Table 1. Rawls's principles of justice and corresponding failings in NHS maternity services

Rawlsian Principle	Definition	Associated Maternity Service Failings	Sources
Equal Basic Liberties	Right to safe, respectful, and dignified treatment.	Dismissive care; denial or delay of essential support; poor communication; limited ability to raise concerns without fear.	CQC (2024); Kirkup (2015; 2022); MBRRACE UK (2025).
Fair Equality of Opportunity	Access to care should not be shaped by social, ethnic, or economic disadvantage.	Ethnic disparities in mortality; inconsistent triage; inadequate safeguarding; inequitable access to specialist review; biased escalation responses.	CQC (2024); MBRRACE UK (2025); Vousden et al. (2024).
Difference Principle	Inequalities permissible only if they benefit the least advantaged.	Funding gaps; staffing shortages; cost driven decision making; organisational defensiveness; weak learning systems.	Darzi (2024); Dyer (2022); Kirkup (2015; 2022)
Veil of Ignorance (Governance Test)	Policies must be justifiable regardless of one's role or vulnerability.	Restrictive visiting policies; weak escalation pathways; commissioning shaped by market incentives rather than continuity and safety.	CQC (2024); Darzi (2024); Maternity Action (2018)

munication found in Kirkup reports requires the adoption of healthcare practice that value mothers' voices, especially when reporting issues of poor care (CQC, 2024). There needs to be a transparent complaints process and redress to any reported harm or injustice and confidence in an NHS response to own up, take responsibility and learn from mistakes (NHS Constitution, 2023). This openness to challenge poor practice requires institutional changes such as the right to complain without fear of recrimination, especially when still an inpatient (Martin et al., 2023). Patient charters tied to enforcement are recommended and mandatory family-involvement with serious incident reviews, could all improve confidence in the process (CQC, 2024).

In a just society, Rawls concept of fair equality of opportunity (FEO) requires that structural barriers such as socio-economic deprivation, ethnicity, gender, geography, do not determine the quality or safety of care received. FEO requires initiative-taking risk-triage and urgent referral pathways for high-risk women; consistent use of safeguarding and domestic-abuse codes (Goldie & Regan, 2025); and equitable access to diagnostics and specialist clinics (RCOG, 2025). Maternity services need to develop a targeted resource allocation to address disparities (e.g., higher maternal mortality among Black women and those in deprivation) as found in MBRRACE-UK, 2025). Institutional levers need to include equity dashboards (a system of tracking maternity service quality indicators) at trust and Integrated Care Board level (NHSE Digital, 2026); equity-weighted commissioning (funding tied to risk-adjusted need); routine inequality impact assessments for service changes (NHSE, 2025).

Rawls difference principle

Rawls's difference principle states that social and economic inequalities are acceptable only if they benefit the least advantaged. There continues to be disadvantage and a lack of action in maternity policy and practice. MBRRACE-UK (2025) identified inequalities due to ethnic and socio-economic factors, such as higher body mass index and hypertension, small for gestational birthweight and higher still-births (NMPA, 2021). Recommendations to address inequalities include a need for more research to inform practice and targeting Black and Asian women with a life-course approach to address the wider determinants of health deprivation, as well as specific risk factors such as smoking (NMPA, 2021). More recommendations are to offer individualised preconception and antenatal information tailored to individual needs e.g. smoking, higher body mass index and pre-existing co-morbidities (NMPA, 2021, p. xii).

Creating a learning organisation—one committed to transparency, cross disciplinary training, and family inclusive review—can counteract the reputational defensiveness observed in multiple inquiries (Dyer, 2022). MBRRACE-UK (2025) identified the need for mandatory high-quality post-mortems; family-inclusive reviews with timelines for implementing recommendations and public reporting of improvements. In multi-professional cultures, stability comes from a shared moral purpose—safe, compassionate care articulated in common training, joint morbidity and mortality meetings, and cross-disciplinary escalation norms. This provides a normative counterweight to reputation management and silo incentives identified in Kirkup.

Conclusion

Across five decades of inquiries, many recommendations have not resulted in sustained cultural or organisational reform. Rawls's framework highlights that justice in healthcare depends on institutional arrangements that ensure equal basic liberties, fair opportunities for safe care, and priority for the least advantaged. To break cycles of harm, reforms must (1) address cultural norms that normalise poor care; (2) counteract objectification through relational, compassionate practice; and (3) align commissioning, regulation and accountability with principles acceptable from behind a veil of ignorance. Only then can the NHS move from lessons learned on paper to a practice of justice that mothers and babies can trust.

References

Beveridge, W. (1942). The Beveridge report. https://archive.org/details/in.ernet.dli.2015.275849

British Medical Association. (2022). Outsourced: The role of the independent sector in the NHS. https://www.bma.org.uk/media/fy3czsaf/bma-nhs-outsourcing-report-september-2024.pdf

Care Quality Commission (2011). Dignity and nutrition inspection programme. Newcastle Upon Tyne: Care Quality Commission.

Care Quality Commission (2013). Time to listen in NHS hospitals. Dignity and nutrition inspection programme 2012. Newcastle Upon Tyne: Care Quality Commission.

Care Quality Commission. (2024). National review of maternity services in England 2022 to 2024. https://www.cqc.org.uk/publications/maternity-services-2022-2024/inequalities

Clement, M. (2023). The founding of the NHS: 75 years on. https://history.blog.gov.uk/2023/07/13/the-founding-of-the-nhs-75-years-on/

Darzi, A. (2024). Independent investigation of the National Health Service in England. https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf

Davies, B. (2019). John Rawls and the 'veil of ignorance.'" In Introduction to Ethics: An open educational resource, 92-97. Golden West College, Huntington Beach, CA: NGE Far Press, 2019.https://open.library.okstate.edu/introphilosophy/chapter/john-rawls-and-the-veil-of-ignorance/

Department of Health. (2012). Compassion in practice: Nursing, midwifery and care Staff. Our vision and strategy. https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

Dyer, C. (2022). Failure to work collaboratively and learn from incidents led to deaths of babies and mothers at Shrewsbury and Telford trust, review finds. British Medical Journal,

376:o858. doi: 10.1136/bmj.o858

Eckert, A. E. (2015). States as social entities: Re- examining the assumption of mutual disinterest in Rawls' law of peoples. Journal of International Political Theory, 1-15. doi: 10.1177/1755088215571

Fritz, Z., Cox, C. (2019). Conflicting demands on a modern healthcare service: Can Rawlsian justice provide a guiding philosophy for the NHS and other socialized health services?. Bioethics, 00:1-8.

Fuse Brown, E.C., Hall, M. A. (2024). Private equity and the corporatisation of healthcare. Stanford Law Review. https://review.law.stanford.edu/wp-content/uploads/sites/3/2024/03/Fuse-Brown-Hall-76-Stan.-L.-Rev.-527.pdf

Goldie, J., Regan, P. (2025). Specialist domestic abuse training for emergency department clinical staff- A review of the literature. Journal of Nursing Theory and Practice, 1, 16-25. https://doi.org/10.17030/uclan.jtnp.615

Goodair, B., Reeves, A. (2024). The effect of health-care privatisation on the quality of care. The Lancet Public Health, 9 (3), e199 - e206. doi: 10.1016/S2468-2667(24)00003-3

Kirkup, B. (2015). The report of the Morecambe Bay investigation. https://assets.publishing.service.gov.uk/media/5a7f3d7240f0b62305b85efb/47487_MBI_Accessible_v0.1.pdf

Kirkup, B. (2022). Reading the signals: Maternity and neonatal services in East Kent – the Report of the independent investigation. https://assets.publishing.service.gov.uk/media/634fb083e90e0731a5423408/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf

Martin, G. (2023). A decade after Francis: Is the NHS safer and more open? British Medical Journal, 380, 513. doi: 10.1136/bmj.p513

Martin, G., Chew,. S, McCarthy, I., Dawson, J., Dixon-Woods, M. (2023) Encouraging openness in health care: Policy and practice implications of a mixed-methods study in the English National Health Service. Journal of Health Services Research & Policy. 2023;28(1):14-24. doi: 10.1177/13558196221109053

Maternity Action. (2018). What price safe motherhood? Charging for NHS Maternity Care in England and its impact on migrant Women. https://maternityaction.org.uk/wp-content/uploads/WhatPriceSafeMotherhoodFINAL.October.pdf

MBRRACE- UK. (2025). Saving lives, improving mothers' care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23. https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports/maternal-report-2021-2023

Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). Report of the Mid Staffordshire NHS foundation trust public inquiry Executive summary. https://assets.publishing.service.gov.uk/media/5a7ba0faed915d13110607c8/0947.pdf

National Maternity and Perinatal Audit. (2021). Ethnic and socio-economic inequalities in NHS maternity and perinatal care for women and their babies. https://maternityaudit.org.uk/FilesUploaded/Ref%20308%20Inequalities%20Sprint%20Audit%20Report%202021_FINAL.pdf

National Health Service Digital. (2021). Nurses, Midwives and Support staff by care setting, level, gender and age: Assessing care using data from births between 1 April 2015 and 31 March 2018 across England, Scotland and Wales. https://digital.nhs.uk/supplementary-information/2021/nurses-midwives-and-support-staff-age-gender-staff-group-care-setting-and-level

National Health Service. (2023). The NHS constitution for England. https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

National Health Service Employers. (2025). Managing organisational change with compassion. https://www.nhsemployers.org/articles/managing-organisational-change-compassion

National Health Service England. (2025). Strategic commissioning framework. https://www.england.nhs.uk/long-read/strategic-commissioning-framework/

National Health Service England. (2026). 2026/27 NHS payment scheme. https://www.england.nhs.uk/publication/2026-27-nhs-payment-scheme/

National Health Service Digital (2026). About the Maternity services data set. https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/about-the-maternity-services-data-set

Maternity Action. (2018). Written evidence from Maternity Action. FDL0082. https://committees.parliament.uk/writtenevidence/96652/pdf/

Rawls, J. (1971). A theory of justice. Cambridge: Harvard University Press. In Ricoeur, P. (2000). The just. Translated by Pellauer, D. The University of Chicago Press: Chicago.

Rawls, J. (1980). Kantian constructivism in moral theory. September. The Journal of Philosophy, 77 (9), 515-572.

Regan, P., Ball, E. (2017). A critical commentary on management science in relation to reforms following institutional National Health Service failures. Journal of Nursing Management, 25, 149-156. doi: 10.1111/jonm.12425

Ricoeur, P. (2000). The just. Trans. by Pellauer, D. The University of Chicago Press: Chicago.

Vousden, N., Bunch, K., Kenyon, S., Kurinczuk, J.J., Knight, M. (2024). Impact of maternal risk factors on ethnic disparities in maternal mortality: a national population-based cohort study. The Lancet Regional Health – Europe, 40, 100893. doi: 10.1016/j.lanepe.2024.100893

Author Biographies

Paul Regan https://orcid.org/0000-0002-8775-933X
Senior Lecturer in Adult Nursing, School of Nursing and Midwifery, University of Lancashire.

Before joining the pre-registration team at the University of Lancashire in 2010, Paul worked in the NHS for 28 years from 1982-2010. Paul has clinical experience of adult nursing, acute mental health nursing and as a generic health visitor.

Elaine Ball https://orcid.org/0000-0002-4551-1416
Senior Lecturer in Adult Nursing, Programme Lead, Professional Doctorate, School of Nursing, Midwifery and Social Work, University of Salford.

Professional experience includes over twenty years of academic teaching. Dr Ball has developed post-registration and post-graduate curricula, teaching methods and teaching; developed learning and assessment systems and led learning and assessment across a multi-professional healthcare field. Her responsibilities include strategy, management of staff and projects.