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Health professionals' experiences of whistleblowing in maternal and newborn healthcare settings: A scoping review and thematic analysis

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ABSTRACT

Problem: Whistleblowing, which involves raising concerns about wrongdoing, carries risks yet can be crucial to ensuring the safety of health service users in maternal and newborn healthcare settings. Understanding of the experiences of health care professionals that enact whistleblowing in this context is currently limited.
Background: Notable inquiries involving maternity services such as those reported upon by Ockenden and Kirkup and the Lucy Letby case in the United Kingdom have shone an international spotlight on whistleblowing failures.
Aim: To identify and synthesise available literature addressing the experiences of healthcare professionals enacting whistleblowing in maternal and newborn care settings.
Methods: This scoping review followed Arksey and O'Malley's framework. Five academic databases were systematically searched for documents published between January 2013 and October 2023 with additional searches of Google Scholar and related reference lists.
Findings: Whilst 35 papers from international sources were identified, the majority originated from the United Kingdom, where recent high-profile incidents have occurred. Thematic analysis identified three main themes: 'Structural Power', 'Perfectionism' and 'Bravery, Hope and Disappointment', each with sub-themes.
Discussion: Whistleblowing is frequently an altruistic act in a hierarchical system. It exposes poor practices and disrupts power dynamics, especially in challenging workplace cultures. Open disclosure, however, requires psychological safety. Obstacles persist, emphasising the need for a culture of trust and transparency led by individuals who embody the desired values.
Conclusion: Primary research on whistleblowing in maternal and newborn healthcare settings is limited. This study sheds light on power dynamics and factors that affect whistleblowing.

Statement of Significance:

Problem/Issue:

Whilst the importance of whistleblowing in maternal and newborn healthcare settings has been well documented, barriers are thought to exist preventing individuals from raising concerns or their concerns being heard and effectively acted upon.

What is Known:

Whistleblowing is an important instrument for safeguarding the safety and quality of maternal and newborn healthcare. Individuals are often actively discouraged by aspects of the organisational structure and culture from raising concerns about unsafe, poor-quality care.

What this paper adds:

An understanding of individual's motivations for whistleblowing in maternal and newborn healthcare settings. The review examines organisational, structural, and cultural forces that limit whistleblowing in maternal and newborn care services and the diverse reactions and responses to whistleblowing.

1. Introduction

With safe and effective maternal and newborn care playing an essential role in optimising health outcomes [52], recent high-profile

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cases of avoidable harm have shone a light on the importance of whistleblowing [32,44,61]. Within healthcare, whistleblowing, commonly called 'speaking up', refers to raising concerns about an observed or suspected issue to effect positive action [63]. Receiving suboptimal care can have devastating impacts on families, particularly when serious adverse outcomes result [15]. Across the broader healthcare literature, workplace and human factors have been associated with poor or inadequate healthcare provision and subsequent harm [31,64]. Whilst organisational and public expectations of maternal and newborn care are high, unsafe, poor-quality care has nevertheless led to unintentional [31] or, less commonly, intentional harm [61]. Inquiries into clusters of adverse maternal and newborn outcomes have suggested the importance of healthcare professionals' whistleblowing when concerns arise about the quality or safety of care [32,33,44].

1.1. Background

In recent years, the importance of whistleblowing in healthcare has been publicly highlighted due to several high-profile adverse incidents suggesting wrongdoing can be overlooked when attempts to speak up are suppressed or ignored [12]. In 2023, neonatal nurse Lucy Letby was found guilty of the murder and attempted murder of infants in her care "in plain sight" between June 2015 and June 2016 [19]. Also in 2015, nurse Christina Aistrup Hansen murdered multiple people in her care in a Danish facility [8]. In both cases, despite colleagues raising concerns, whistleblowing was ineffectual, likely due to individual, cultural, and organisational barriers [20]. The broader healthcare literature has highlighted that the workplace culture, established hierarchies, and power imbalances frequently encountered within healthcare settings can contribute to the sense of voicelessness [30] by either suppressing voice [29], or muting responses to concerns raised [46]. Despite the clear need for healthcare professionals to be able to speak up openly and honestly when concerns arise, barriers to this consistently occurring exist. The United Kingdom (UK), where in recent years some of the most high-profile cases have occurred, the voices of concerned colleagues were found to be stifled, ignored, or overtly silenced, with tragic consequences [51,61]. As a result of such cases, the UK now has policies and structures designed to support healthcare staff seeking to raise concerns. Examples include policies on whistleblowing and the Nursing and Midwifery Council's (NMC) and General Medical Council's (GMC) Duty of Candour guidance [25].

To date, no attempt has been made to formally identify and synthesise what is currently known about the experiences of healthcare professionals enacting whistleblowing in maternal and newborn healthcare settings. This scoping review aims to fill that gap by examining this phenomenon.

2. Methods

2.1. Design

Arksey and O'Malley's five-step methodological framework guided the scoping review process [3] contributing to the review's transparency and rigour. At stage one we identified the research question. At stage two, we identified the relevant studies. At stage three, we selected the studies. We charted the data at stage four, and at stage five, we collated, summarised, and reported the results.

A scoping approach was selected to enable a better understanding of the nature, extent, and breadth of the literature available on this topic, and to identify any gaps in knowledge [3]. It is anticipated that the findings of this review will inform further research on this topic by the authors.

Traditionally the methods used to organise and present results in scoping reviews are descriptive, however, due to the nature of the topic and the aims of the review, thematic analysis [4], was used to analyse, and present the findings. Reporting followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA – ScR) checklist [62] (Appendix 1).

2.2. Search methods

A preliminary literature search was conducted to establish the key terms frequently used in the literature on this topic. These were then used to develop the search strategy and the inclusion and exclusion criteria. The literature available between January 2013 and October 2023, was identified by systematically applying the search terms presented in Table 1. to PubMed, Embase, Web of Science, Medline, and Cumulated Index to Nursing and Allied Health Literature (CINAHL) Ultimate databases. Truncation symbols and Boolean operators were utilised to target the search strategy. An example of the full search strategy applied to Embase can be found in Appendix 2. Follow up searches were then conducted in Google Scholar using the same search terms to identify any grey literature, reports, or other literature on the topic of interest and the relevant reference lists of the included articles. The inclusion period of January 2013 to October 2023 was selected to ensure currency and relevance of the literature. In the prior decade, whistleblowing within maternity services gained public prominence arising from technological and media advances. This has resulted in greater reporting of the process and outcomes of investigations into maternity services leading to public outcry.

2.3. Search outcome

Initial database and hand searches identified 408 documents for import into Covidence [9], a systematic review management software package. Of these, 136 were duplicates and removed. The titles and abstracts of the remaining 272 documents were screened and a further 169 excluded.

2.4. Inclusion and exclusion criteria

The full text of the final 103 documents were assessed against the inclusion and exclusion criteria presented in Table 2. A further 68 documents were excluded. The reasons for exclusion are presented in Fig. 1. The PRISMA flow diagram [48].

2.5. Quality appraisal

As per Munn et al., [42], as this scoping review aimed to identify and synthesise what is currently known about the phenomenon of interest, document quality appraisal was not undertaken.

2.6. Data abstraction

Key data were extracted from the included 35 documents using a standardised tool. The authors' names, publication year, geographical origin, study methods, participants, and relevant findings were charted. Table 3 presents the data extracted.

2.7. Synthesis

All included documents were read in their entirety by each member of the authorship team and the key relevant findings agreed. The charted findings were then thematically analysed by each author, guided by Braun and Clarke's six-stage framework (2006). Initial codes were developed by grouping the findings, and broader codes were developed and merged to form preliminary themes. In the context of the coded excerpts, the merged codes were then re-examined, and through further refining, the themes were finalised and named. The authorship team met regularly to discuss the analysis process and agree the final themes. Conflicts were resolved by consensus. The third section of this manuscript presents the findings.

Table 1
Search terms.

[midwi* **OR** 'nurs* **OR** medic* **OR** 'healthcare profess*' **OR** 'healthcare work*'] **AND** [matern* **OR** obstetric* **OR** birth*] **AND** [service* **OR** car* **OR** unit*] **AND** ['complain*' **OR** 'concern*' **OR** 'whistleblow*' **OR** 'Speak* up' **OR** 'notif*' **OR** 'disclos*' **OR** 'voic*'] **AND** ['poor practice*' **OR** 'unsafe practice*' **OR** 'dangerous practice*' **OR** 'high risk' **OR** 'harm* practice*' **OR** 'malpractice' **OR** 'negligence' **OR** 'litigat*' **OR** 'misconduct' **OR** 'patient safe*' **OR** 'adverse outcome*' **OR** 'patient risk*' **OR** 'unsafe care' **OR** 'safety concern*' **OR** '*ethical practice' **OR** 'professional mistake*' **OR** 'professional error*' **OR** 'clinical error*']

Table 2
Inclusion and exclusion criteria.

Included	Excluded
All types of available documents. In English and made available between Jan 2013 – Oct 2023. Full text available. Literature discussing whistleblowing including all types of registered healthcare professionals working within maternal and newborn healthcare settings as either the whistleblower and/or the focus of the whistleblowing complaint. Literature exploring any aspect of whistleblowing about the safety and quality of maternal and newborn healthcare. Literature that arrived at findings related to any aspect of whistleblowing about the safety and quality of maternal and newborn healthcare.	Literature exploring whistleblowing *only* in other areas of the healthcare setting. Literature exploring whistleblowing *only* involving students or non-registered healthcare workers (midwifery assistants). Literature that *only* included the experiences of academics. Literature that *only* included the experiences of doulas. Literature that *only* included the experiences of consumers. Literature presenting studies where it was not possible to differentiate the healthcare professionals' findings from other participants. Blog or forum posts where the author/s were unable to be identified.

3. Findings

Thirty-five (35) documents were included in the final analysis. The papers originated from eight countries, primarily the UK (25 papers), with the balance from the United States (3), Australia (2), Canada (1), Norway (1), Lithuania (1), Sweden (1) and the Republic of Ireland (1). Of the included papers, eight examined primary data, with two reporting mixed methods studies, three qualitative studies, and three quantitative studies. The balance included discussion papers (4), editorials (3), literature reviews (2), reports (4), news articles (3), commentaries (9), an expert review (1) and a letter to the editor (1). As the authors sought to capture all types of literature, any document referring to the phenomena, and meeting the inclusion criteria were included.

3.1. Themes

Thematic analysis [4] led to the identification of three overarching themes: 'Structural Power', 'Perfectionism' and 'Bravery, Hope and Disappointment', each with further sub-themes. While each theme exhibits distinct characteristics, they demonstrate a spectrum throughout the findings, encompassing systems, reporting, responses, and the individual, that are interconnected and mutually related. These themes and their subthemes will now be explored.

3.1.1. Theme one: structural power

The pivotal role that structural power plays in the healthcare setting was a strong theme in the literature. Structural power is present in all organisations, but in healthcare structures are highly hierarchical, designed for efficient functioning, and also giving rise to a culture of projecting confidence and concealing vulnerability, discouraging individuals from speaking out due to fear of repercussions such as scrutiny,

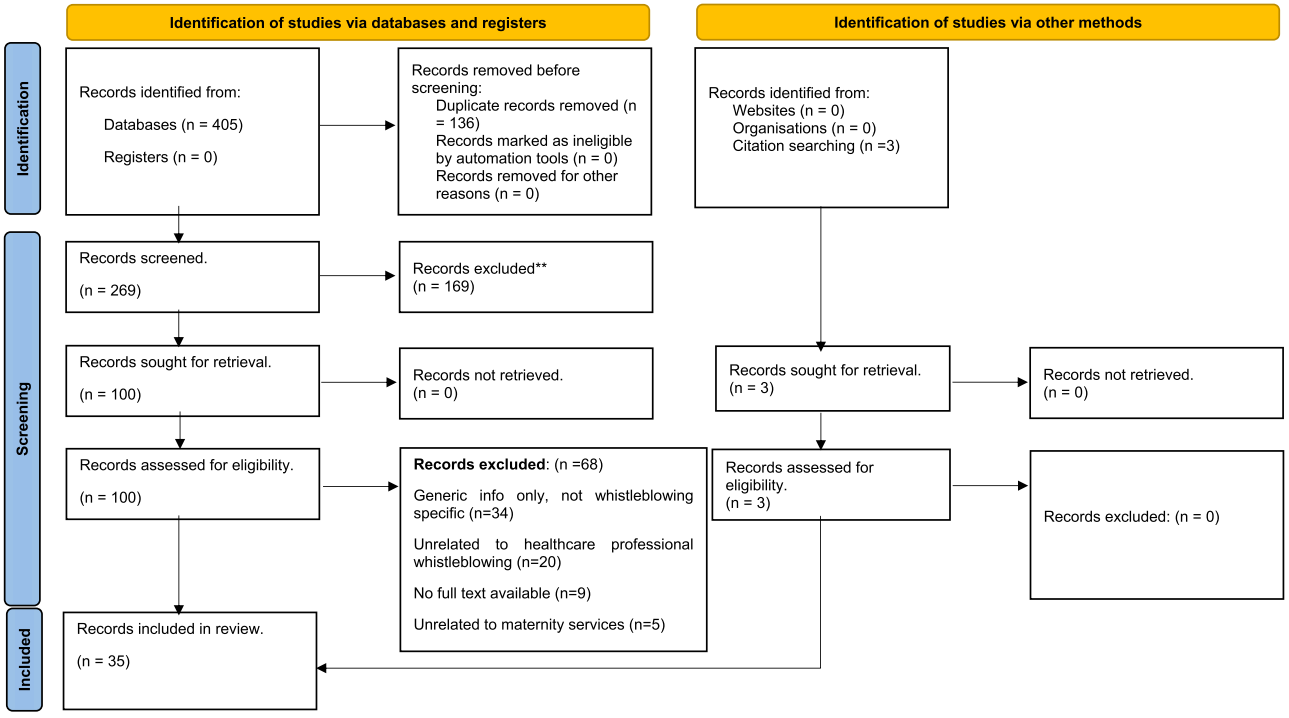

Fig. 1. PRISMA Flow Diagram. *From:* Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. Doi: 10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/.

Table 3
Data Extraction.

Author/s, Year, Country	Document Type/ Aim/Purpose	Population	Sample Size	Methods	Key relevant comments/findings/ conclusions
Allen and Anderson [2] **UK**	Discussion paper: exploring challenges for new midwives, addressing professional shortcomings, and navigating whistleblowing.	Newly qualified midwives	Unknown	N/A	Newly qualified midwives find it challenging to report on senior midwives' poor practices, fearing negative repercussions, job implications, and being perceived as treacherous by colleagues.
Catling et al., [7] **Australia**	Qualitative research paper exploring midwifery workplace culture from the perspective of midwives.	Australian midwives	23 midwives	Individual and group interviews. Thematic analysis.	Midwives experience workplace bullying. The organisation often ignored clinical concern emails and unaddressed practice issues. Reluctance to ensure evidence-based practice leads to silence and few expressing concerns, especially in rural areas.
Crompton [10] **UK**	Report: Assessment of leadership and management in Bedford Hospital NHS Trust's Maternity Services.	Maternity unit staff.	Not stated.	Document review, employee interviews, and midwife focus groups.	Maternity care staff blew the whistle to the Care Quality Commission (CQC). Managers were not hearing concerns, and staff feared speaking out due to disciplinary policy. Some were unfairly blamed and hesitant to speak up. Managers' decisions were inconsistent in response to complaints.
Crowe and Manley [11] **UK**	Literature review of past maternity service inquiries for NHS best practices and contextual considerations.	Maternity services staff	Five inquiries, three national reviews, and 17 key service publications.	Thematic analysis.	Being able to challenge poor practice is essential. Creating a safe environment for staff to raise concerns would support safe practice—the need to escalate safety risks to enable corrective action.
Dixon-Wood [13] **UK**	Editorial on NHS Trust's failure to provide safe maternity services.	Maternity services staff	unknown	N/A	Bullying and harassment were common, and staff feared speaking up due to inadequate human resource processes and weak psychological safety systems. Anonymous concerns were ignored, and leadership failed to provide guidance or act.
Dobson [14] **UK**	Letter to the editor discussing how a nurse was found guilty of murdering seven babies was missed, and whistleblowers were ignored.	N/A	N/A	N/A	A nurse harming infants highlighted missed intervention opportunities and raised staff concerns about failures. Despite initiatives like the National Guardian's Office, challenges persist. Hospitals should prioritise action over reputational concerns.
Dyer [16] **UK**	News report: NHS trust fails to meet CQC improvement demands - professional journal.	Maternity services staff	N/A	N/A	Not all recommendations were implemented, but the follow-up report said the Trust had new leadership and management. Consequently, staff felt more confident raising concerns and being heard.
Dyer [17] **UK**	News report: Discussing how the health regulator had previously warned of failings at an NHS Trust.	Maternity services staff	N/A	N/A	A whistleblower informed the CQC of six newborn babies suffering brain injuries. Investigations revealed that previous concerns were left unaddressed, and there was a lack of collaboration and an absence of an open culture within the healthcare facility. Nine whistleblower complaints about leadership were received with ineffective responses.
Dyer [18] **UK**	News Report: UK maternity services need urgent improvement.	Maternity services staff	N/A	N/A	Fourteen whistleblower complaints reported a "blame culture" and understaffing concerns with no response in the maternity service system.
Elliott-Mainwaring [21] **UK**	Commentary: A midwife's reflection on whistleblowing in the NHS.	Midwives	N/A	N/A	A midwife raised concerns about staff shortages but was labelled a liar. Fearing whistleblowing, management summoned her. Complaints to the Head of Midwifery were ignored. Entering a Datix risk report led to a reprimand. Speaking out is risky. Courage and evidence are necessary

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Table 3 (*continued*)

Author/s, Year, Country	Document Type/ Aim/Purpose	Population	Sample Size	Methods	Key relevant comments/findings/ conclusions
					for effective follow-through and self-protection.
Elliott-Mainwaring [22] **UK**	Commentary discussing a broad perspective of maternity services safety.	Maternity services staff	N/A	N/A	Healthcare prioritises brand over safety. Speaking up can be risky. Power dynamics make staff feel unsafe.
Goodwin [27] **UK**	Discussion paper: Examining the Morecambe Bay report.	Maternity services staff	N/A	N/A	Transparency is crucial in identifying workplace issues, but fear and secrecy can lead to poor standards of care and unreported incidents and hinder effective performance. Prioritising transparency, trust and accountability is essential for a safe and healthy work environment.
Kirkup [32] **UK**	Report on an independent investigation into perinatal care provided by Morecambe Bay NHS Trust.	Maternity services staff	N/A	N/A	No concerns were raised after five serious incidents. Combining complaint handling and support roles was inappropriate. Whistleblowers were disappointed by how colleagues and managers treated them. New recruits needed to be informed about the whistleblowing process, as only 68% of staff felt safe raising concerns.
Kirkup [33] **UK**	Report on an independent investigation into the maternity services in East Kent.	Maternity services staff	N/A	N/A	Midwifery leaders left due to a culture of bullying and intimidation. Midwives expressed fear of speaking up and were discouraged from proposing alternatives. Despite efforts to combat it, bullying remained prevalent. The Trust has several Freedom to Speak Up Guardians, but they lacked dedicated time. Poor leadership and an inability to listen were recurring themes in public safety speak-ups. Senior staff involvement in bullying was particularly challenging.
Kirkup and Titcombe [34] **UK**	Editorial discussing the importance of whistleblowers in light of Lucy Letby's sentencing.	Maternity services staff	N/A	N/A	Doctors warned management about a neonatal nurse who was later convicted of causing multiple neonatal deaths. Managers ignored them, prioritising reputation over problem-solving. Whistleblowers faced denial, deflection, and cover-up, leading to further needless tragedy.
Lyndon et al. [35] **USA**	Commentary exploring communication and safe intrapartum care.	Maternity services staff	N/A	N/A	Healthcare professionals may refrain from reporting safety or clinical issues, fearing retribution. Speaking up is essential for better care.
Mander [38] **UK**	Mixed methods study on challenges that impact midwives' perceptions of safety.	Midwives	280 midwives	Online survey with open & closed questions.	Midwives avoid reporting incidents due to fear of blame or being labelled as troublemakers. Only 20–30% of incidents are reported due to bureaucratic process. Reporting concerns is crucial for midwives to prioritise safety as per The Code.
Maxfield et al. [39] **USA**	Expert review: Assesses safety concerns during labour and birth.	Physicians, midwives, and nurses.	3282 participants: 985 doctors, 414 midwives, 1884 nurses.	Participant Survey	Silence among healthcare workers can cause adverse events and system failures. Organisational violence can silence witnesses. Effective communication and teamwork lead to better outcomes.
Morris [41] **Australia**	Mixed methods research paper exploring how midwives communicate concern to support intrapartum safety.	Practising midwives.	65 midwives across five regional maternity service facilities in NSW.	A self-administered questionnaire followed by focus-group discussions with registered midwives.	A total of 96% of midwives reported witnessing safety concerns, including care providers performing procedures without informed consent. However, only 12% spoke directly to the person responsible due to fear of retaliation.
Newdick [43] **UK**	Commentary: Analysis of hospital inquiries, recommended reforms, and regulatory bodies for public safety."	Maternity services staff	N/A	N/A	Managers tend to prioritise concealing problems and avoiding public criticism, creating a culture of bullying and a lack of accountability. Staff members are often afraid to admit their mistakes, leading to a

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Table 3 (*continued*)

Author/s, Year, Country	Document Type/ Aim/Purpose	Population	Sample Size	Methods	Key relevant comments/findings/ conclusions
					culture of cover-ups where institutions close ranks around lies.
Ockenden [44] **UK**	Report: Summarises the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, including Findings, Conclusions and Essential Actions.	Women, families, maternity unit staff, medical records.	1486 families. 1862 family cases. Maternity unit employees. Medical records from 1592 clinical incidents.	Participant interviews with families and staff. Review of medical records and governance documents.	Managers mishandled complaints, discouraging staff from speaking up and creating a culture of fear. Escalating concerns was challenging due to a punitive culture, hindering professional or clinical issue reporting. Staff expressed fear of retribution, describing a pervasive culture of silence and difficulty in speaking out about a long-standing pattern.
O'Neill [45] **UK**	Editorial discussing the 2015 review 'The Freedom to Speak Up'.	Maternity services staff	N/A	N/A	Over 260 healthcare staff and 300 Trusts received whistleblower training, but the 300 guardians created to support whistleblowers have only 4 hours per week time allocation. Poor response to whistleblowing raises concerns like mistreatment of whistleblowers, defensive organisations that don't investigate, and issues being swept under the carpet.
Pack et al., [47] **Canada**	Qualitative research paper discussing team leaders' subtle behaviours and actions that both promote and discourage speaking up.	Healthcare professionals.	Thirty-nine participants, including obstetricians, midwives, and nurses.	The study utilised interprofessional simulation scenarios and semi-structured interviews.	Approachable team leaders encourage staff to voice their concerns, promoting safety and positive outcomes. Failure to engage in approachable behaviours can have negative consequences, as even subtle cues from the leader may hinder approachability. Listening is essential for team leaders to promote safety.
Powell [50] **UK**	Commentary presenting a case study of the Morecambe Bay Inquiry.	Maternity services	N/A	N/A	Discussion on the Morecambe Bay inquiry emphasising the importance of organisational culture. Explores "normalisation of deviance," "sociology of disasters" and "organisational silence." "Comfort-seeking behaviour" describes how comfort is prioritised over safety. Nurses whistleblow more than doctors, but it promotes blame culture. Staff need to feel secure, but management is often unwilling to act.
Ribeliene et al. [54] **Lithuania**	Quantitative research paper evaluates staff opinions on safety issues and predictors for the overall perception of safety.	Nurses and midwives working in the maternity care setting.	233 respondents; 62 midwives, 71 anaesthetic and intensive care nurses, 18 operating room nurses, and 81 nurses.	A survey on patient safety culture assessed participant perceptions of safety culture.	Only 53.2% of staff members were willing to speak up when noticing poor care. Communication openness and teamwork were lacking, and respondents reported insufficient staffing. Only 1/3 of respondents believed mistakes were discussed without punitive action. However, 82.4% of respondents reported that mistakes were frequently or always reported when caught before affecting the woman.
Royal College of Midwives [55] **UK**	Commentary. RCM emphasises public safety and speaking up about poor work environments.	Maternity services	N/A	N/A	Collaboration between professional bodies, unions and employers is key to creating a safe work environment where healthcare staff can report concerns without fear. It is important to identify workplaces that discourage reporting of concerns. The RCM is working to address non-compliant workspaces. Despite Duty of Candour and whistleblower policies, staff members still face ignorance and silencing when raising concerns.
Sekar et al. [56] **UK**	Discussion paper recommends senior doctors acknowledge fallibility and support junior team members to create a safe working environment.	Maternity services staff	N/A	N/A	Inadequate care, poor communication, and flaws in teamwork cause half of maternal deaths. Speaking up is difficult due to hierarchies and fear of retribution. Empowering staff, assigning non-

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Table 3 (*continued*)

Author/s, Year, Country	Document Type/ Aim/Purpose	Population	Sample Size	Methods	Key relevant comments/findings/ conclusions
					confrontational guardians, and dismantling hierarchies are essential to prevent deaths. Training on non-technical skills and debriefing teams can help address steep authority gradients.
Severinsson et al., [57] **Norway**	Systematic Literature Review identifying obstetric adverse events (AEs) and near-misses in the context of safety.	Obstetric adverse events in Europe, Australia, USA – papers published.	9 Papers	Thematic analysis	Examines healthcare professionals' attitudes towards ethical conflicts and responsibility attribution. Effective communication, supportive leadership, and psychological safety are important strategies for ensuring public safety. Trust is crucial for establishing healthy relationships, and teamwork is necessary for creating an environment for learning.
Simms et al. [58] **UK**	Qualitative research report investigating the experiences of staff directly involved in risk management.	Obstetric and midwifery risk management leads.	A total of 27 staff from 12 maternity units participated. The roles of the participants were not stated.	Semi-structured interviews.	Staff use unreliable data collection systems, leading to misinterpretation of client data and inaccurate statistics. External demands for data add to risk management workload with unclear benefits. Financial constraints hinder risk management. Maternity unit culture is critical to quality care and staff motivation for risk management.
Taylor and Goodwin [59] **UK**	Commentary arguing for a better connection between medical ethics and public safety curricula using the report of The Morecambe Bay Investigation as a case study.	Maternity services	N/A	N/A	Normalisation of Deviance (NoD) occurs when potential danger is deemed normal, reducing the effectiveness of whistleblowing. Organisational complexity and structural secrecy impede interpretation and problem-solving. Whistleblowing is a vital step, but it's only the beginning of a larger process that identifies risk and finds ways to address it.
Vize [65] **UK**	Commentary providing discussion on the Ockenden report.	Maternity services staff	N/A	N/A	Hospitals faced clinical failures, poor leadership, and a lack of accountability. The board whitewashed investigations and blamed whistleblowers. Problems were able to keep occurring.
Wahlberg et al., [66] **Sweden**	Quantitative research paper on severe events in the labour ward and subsequent investigations and complaints.	Midwives & Doctors.	1459 midwives and 706 doctors	Cross-sectional survey/ questionnaire	Doctors and midwives routinely experience adverse events, leading to emotional strain. Formal investigations seldom provide adequate feedback for closure. The governing body can discipline healthcare providers through caution, warning, or sanctions.
Watson and O'Connor [67] **Ireland**	Discussion paper exploring the importance of client advocacy.	Health services inclusive of maternity services	N/A	N/A	A maternity services review identified the need for the establishment of an independent patient Advocacy Agency to enable staff to 'stand up' for or whistleblow on behalf of clients when required. Effective client advocacy requires morality and shared humanity but whistleblowers face risks such as powerlessness, fear, and lack of support leading to moral distress, isolation, and legal vulnerability. Whistleblowers in all healthcare settings lack protection, risking harm. Failing to report safety concerns violates the professional codes of conduct for all health professionals. Legal protection is not enough to encourage clinicians to speak out. Professional bodies need clearer roles in whistleblowing. The camaraderie among clinicians can have positive implications but creates a culture of ostracising whistleblowers.

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Table 3 (*continued*)

Author/s, Year, Country	Document Type/ Aim/Purpose	Population	Sample Size	Methods	Key relevant comments/findings/ conclusions
Wilkinson [68] **UK**	Commentary discussing toxic tribalism in maternity care and the need to address this.	Maternity services staff	N/A	N/A	Breakdown of teamwork, professionalism, and compassionate care have been discovered in maternity services. Toxic cultures marked by bullying, group mentality, and reputation-focused management led to defensiveness rather than proactive learning from errors. Midwives' stress and anxiety caused experienced professionals to leave, depriving the industry of valuable leadership. Continuous development, task forces, and reasonable sanctions for poor behaviour are recommended.
Zabari and Southern [69] **USA**	Quantitative research paper: discussing shame and guilt, coupled with organisational factors, which affect error reporting by staff.	Obstetric clinicians: nurses and doctors.	A total of 84 participants.	Questionnaire. Test of Self-Conscious Affect used to measure guilt and shame.	Clinicians' error reporting is influenced by guilt, shame, hierarchy, and fear of punishment. To create a supportive environment, colleagues should show concern, avoid blame, and offer positive reinforcement.

blame, and disrespect [10,13,18,2,21,22,33–35,43–45,47,50,65,66,69]. The hierarchical nature of the healthcare setting however means that to voice concerns, individuals need to muster considerable courage. Speaking up risks upsetting the established power structure, into which the whistleblower may be integrated. The structure may passively inhibit whistleblowing, or actively respond to protect both the system and its reputation at the expense of those who dare to challenge it [13,14,22,34,43,68]. As a result, whistleblowers find themselves muted, encouraged to join a prevailing silence. Structural power is subsequently maintained at the expense of women's and infant's safety [13,14,34,39].

3.1.1.1. Sub-theme: being silenced and structural secrecy. Being silenced suggests an active suppression of an individual's voice, rather than it simply becoming lost in the noise of a busy organisation. The dynamics of being silenced are often shaped by the expectation and reality that concerns are reported directly to the employer of the whistleblower or their agents [7,13,21,32,33,38,44,47,50,55,56,59,65,67,69]. The employer has a vested interest in quality of care, but also the organisations reputation and risk mitigation. This does not necessarily align with the whistleblower's intent, creating barriers, leading to the dismissal of concerns [7,13,16,34,59], being ignored [21,55,57], issues being buried [43,45,55], or blame being deflected [13,18,47,65,69]. This may manifest as accusations of being vindictive and telling lies [21] or being mentally unfit [44,65].

Indirect suppression becomes apparent in the lack of robust support mechanisms and complex, time-consuming reporting systems [38]. These factors collectively contribute to a work environment marked by moral injury [47,67], diminished job satisfaction [44,68] and pose an increased risk of adverse outcomes for mothers and babies [14,17,32–34,39,41,44,47]. Furthermore, organisational structures that endorse secrecy further support this, particularly gaining prevalence in systems where structural secrecy burgeons with increasing complexity [17,59]. In such environments, teams are dysfunctional, signals mixed, outcomes vary, and positive organisational performance is reported despite the presence of 'red flags' [13,17,68]. The complexity, in part, allows incidents to be hidden; incidents are perceived as coincidental rather than interconnected [14,34]. Consequently, structural secrecy solidifies poor outcomes, leading to inadequate adverse event investigations, hampering closer re-examination of previous incidents, further reinforcing the existing secrecy culture [27,32,33,44,59,65].

3.1.1.2. Sub-theme: lack of governance and support. A breakdown or paucity of governance and support emerged as a sub theme. Governance relates to policy and procedure around speaking up in this instance, and support the provision of resources to staff in voicing concerns. The lack of fit-for-purpose investigation processes was noted in the literature [10,11,13,38,39,55,65]. Such shortcomings have a range of drivers. One paper highlighted the damage caused by high staff turnover, reducing the availability of experienced managers, and promoting inexperienced junior staff who have progressed from frontline roles into management positions without adequate preparation [68], or the ability to respond appropriately to adverse outcomes [57]. Limited training and professional development were also identified as constraining the ability to address issues efficiently and effectively [11,54,56,58,68]. This theme connects to the previous, as managers who lack the resources and skills to deal with issues raised seek to silence them to preserve their reputation and employment.

3.1.1.3. Sub-theme: inadequate action in response to complaints. In the context of inadequate action in response to complaints, where formal systems exist, preserving the organisation's reputation is prioritised over addressing whistleblowers' concerns [22,43,65,68]. These responses may range from either actively disparaging or attacking the complainant to responding superficially to the complaint. Minimal response to concerns helps perpetuate disrespect, dysfunctional teamwork, communication issues, fitness to practice, and understaffing [7,10,18,22,43,45]. This lack of response, or inappropriate response, in turn, discourages potential whistleblowers [27,33,44,67].

Moreover, whistleblowing faces impediments due to the insidious process of normalising poor practices [39,43,50,59]. This is exemplified by defensive phrases such as 'that is how it's always been done' or 'that's how we do it here' [68]. Those who resist such characterisations risk bullying and retribution 'in defence of' the practice and reputation of colleagues [34,35,44,47,54]. The organisational culture becomes characterised by toxic tribalism; a group mentality concerned with turning a blind eye and minimising reputational damage rather than prioritising the safety of mothers and babies [14,18,44,68].

3.1.2. Theme two: perfectionism

Healthcare organisations naturally strive to avoid errors, but even when errors occur, try to project flawless performance. To the public, the system cannot appear unsafe, and hospital hierarchy must be viewed as perfect and vigilant, watching for risks and promptly addressing them to sustain public trust. Anything short of "perfection" might be characterised as inadequate. Whistleblowing threatens the perception of perfection. It exposes the group, hierarchy, and system deficiencies [22,67,68]. Again, the levels of the hierarchy who are tasked with the maintenance of the image of perception, may be invested in portraying

frontline workers as outliers and scapegoats [22,39,43,65]. However, the drive for perfectionism may also operate at the frontline, who may themselves have adopted this impossible standard, which may give rise to feelings of shame and guilt, inhibiting self-reporting of errors to avoid scrutiny and humiliation [2,66,68,69].

3.1.2.1. Sub-theme: oppression and ostracisation – do not rock the boat. The sub-theme oppression refers to the policing of efforts to actively suppress whistleblowing [7,10,14,32,34,38,44,56,57,66]. Healthcare professionals undertaking whistleblowing face reactions such as bullying, real or threatened reputational damage, blame-shifting, ostracisation and job loss [2,7,10,27,32,34,39,43,44]. These responses, particularly for lower-level healthcare professionals, may represent a significant threat. Scapegoating becomes the norm, deflecting blame away from systemic issues and prioritising self-preservation over the needs of women and infants [10,18,43,50,57,65,69]. Continuation and preservation of public trust in the system becomes the priority [14,22,34,68] rather than meaningful change, which is costly and resource-depleting. This links to the theme of structural secrecy, which fosters a culture of silence via intimidation, shaming, and humiliation. Power dynamics of the system and power gradients between individuals within the hierarchy are at work here, hindering whistleblowing [22,47,56,69].

3.1.3. Theme three: bravery hope and disappointment

Whistleblowing commences as a step fuelled by the desire for acknowledgement of wrongdoing and acting as a call for action [21,32,47,55,56]. While it may appear to be a modest step considering the consequences of inaction, the previous themes illustrate that this requires considerable bravery. However, the real work occurs when the recipient actively listens and positively responds to the whistleblower and the identified wrongdoing [34,50,56,57,59,68,69]. This is where the loop begins to close. Neglecting whistleblowing responses constitutes a breakdown in the process, thus risking public safety and losing staff hope and trust in management [14,16,22,33,44,59]. Whistleblowing involves dismantling established hierarchies, representing an immediate conflict between whistleblowing and the system [43,56,69]. Recognising this conflict requires acknowledging power gradients [56], underscoring the importance of recognising the distance between individuals and those capable of effecting change.

3.1.3.1. Sub-theme: tokenism. Instead of organisations having a substantial response to whistleblowing, their reluctance to resource targeted strategies results in superficial, tokenistic changes that merely signal a response to the act of whistleblowing. While these changes give the impression of positive action, they do not address the issues that lead to the act of whistleblowing [7,10,14,18,21,43–45,50,55,57,59,65,67]. Limited financial and human resources are barriers to fundamental, sustainable transformation, leaving individuals with concerns and few options for escalation and impactful change [58,67]. Tokenistic efforts, such as hospital managers reporting to regulatory bodies, making recommendations, or even the conduct of investigations may provide a semblance of action and improvement but fail to address the root causes; hence, history repeats itself, as evidenced by the ongoing reports on maternity services over recent decades [66,67].

3.1.3.2. Sub-theme: the individual vs. the system. This sub-theme highlights the inequity of the (often lone) whistleblower facing the established status quo of *the system*. Individuals must choose between their own self-interests and career, versus challenging the system to safeguard women and infants [2,11,18,21,22,32–34,43,44,47,56,59,65–67]. Whistleblowers face ostracisation, accusations, and loss of employment [2,22,38,67]. Reporting to managers, who are often accountable for their units, creates an intimidating environment [56,67]. The system may normalise poor practice and going against the group risks exclusion for the whistleblower [34,35,41,44,67–69]. This struggle between individual actions and the system's resistance adds a layer of complexity to the already complex landscape of whistleblowing in maternal and newborn care settings.

4. Discussion

This scoping review has identified the literature available since 2013 related to healthcare professionals and whistleblowing about the safety and quality of maternal and newborn care. Whilst the literature is relatively limited, collectively it suggests that the effective functioning of a reporting culture is important and can be encouraged by ensuring responsive leadership [47]. The broader literature suggests that being a responsive leader requires interactional relationships with outcomes that have direct impacts for the effective management of reported wrongdoing [5]. The findings suggest that the decision to whistleblow is often an individual act of altruism within a regimented and hierarchical system, leading to isolation and distress. However, while the pathway may be individual, the individual needs organisational support. By speaking out, whistleblowers must be prepared to place the needs of others above their own. Pezaro et al., [49] supports this suggesting that whistleblowers often choose to speak up, driven by the moral injury of witnessing the suffering of others and motivation to expose the truth. By its very nature, whistleblowing exposes poor or unethical practices that can, within some organisations, be widespread and systemic, thus disrupting established power gradients [28]. Elliott-Mainwaring [22] suggests that this is particularly the case in maternity care settings where established hierarchies and challenging workplace culture are known to already exist. Furthermore, this review has demonstrated that whistleblowing can lead to workplace bullying and isolation, which the broader literature highlights contributes to psychological distress [6]. There is potential for this to be further exacerbated when clinicians such as those captured in this review risked accusations of disloyalty, lack of discretion and were accused of having an axe to grind [38]. However, professional, and ethical standards of practice mandate that healthcare professionals uphold the safety of mothers and babies, ensuring quality care, creating a conflict between their own beliefs, the employers' expectations, and the professional standards, leading to further moral distress [38]. Psychological safety is required to raise concerns and encourage open disclosure, creating an environment where individuals feel comfortable speaking up about wrongdoing without fear of reprisal [11,36]. When there is psychological safety, whistleblowers are more likely to report concerns, fostering transparency and accountability. Without this safety net, the fear of retaliation deters speaking up, thus hindering the identification and resolution of problems. Psychological safety and open disclosure are imperative to safety and quality, as is a culture of transparency and trust. Healthcare organisational culture has historically been known to lead to fear of speaking up and fear of backlash [44], and this appears to be particularly true in maternity services.

Organisational culture is shaped by leaders who embody the values and behaviours they wish to see reflected in their employees. Approachability is a crucial attribute for leaders within the hierarchy so that staff feel safe raising concerns [47]. Compassion, empathy, and the preparedness to listen to others' concerns are crucial for leaders to embed collegial trust and promote safety [47,68]. For leaders to foster organisational cultures that support open disclosure, they must address perfectionism; high standards are laudable, but unrealistically high standards can muffle employee voices. This entails promoting a growth mindset, emphasising learning from mistakes, and cultivating the psychological safety required to learn from errors so that individuals feel empowered to speak up without fear of reprisal [1]. Encouraging a culture that values improvement over perfection contributes to a more resilient and adaptive organisation; however, socio-emotional elements of care provision in modern organisations often impede this [37].

With access to modern technology and evidence-based practice,

contemporary maternity services are held to high expectations, promoting a view that childbearing is risk-free, controllable, and predictable [40]. Adverse incidents are consequently attributed to human error leading to reputational damage, shame, humiliation, and punishment for staff and the organisation [1]. This can result in managers responding defensively, deflecting blame, or scapegoating their subordinates to safeguard organisational reputation and protect self-interests [61]. Staff, therefore, feel unsupported and powerless as the system pits them against it, driving compliance and silence [53]. Poor organisational and structural working conditions, bullying culture, and institutional normalisation of dysfunction are common (Elliot--Mainwaring, 2021), exacerbating issues further.

This culture of silence can repress whistleblowing, despite staff no longer tolerating 'substandard' care. Gidden's Structuration theory (1984) and Foucault's [24] theories on power offer frameworks to conceptualise how power and organisational structures compel silence and constrain whistleblowing. Power broadly refers to the ability to influence, control, or direct others or the course of events and manifests in various forms, including physical force, authority, knowledge, or social influence. Power gradients are prevalent within the social world of healthcare across interpersonal relationships, hierarchies, and organisations shaping the behaviour, decisions, and outcomes of both the individual employees and the maternity services they work within [60]. Power is complex and has multifaceted mechanisms impacting individual healthcare professionals and maternity services. Foucault describes institutional power as circulatory and dispersed, driving compliance to avoid punishment [23,24]. Institutional acts of power and coercion operate through discreet structures within hierarchical systems such as maternity services. While exercising personal power remains an option for the midwife, it may lead to marginalisation or exclusion. In a robust system, power can influence which discourse dominates, thus reinforcing the status quo. The discourse supported by a strong maternity service reinforces its expert and trustworthy reputation to the public. This incentivises the concealing of flaws to control discourse and project a positive reputation for social and economic advantage.

Whilst whistleblowing can destabilise the status quo and threaten the organisational hierarchy and its portrayed reputation, it is essential for healthcare professionals to consider the significance of not reporting in terms of public safety, moral injury, and the professional codes and standards. Recent highly publicised cases have illustrated this. For example, neonatal nurse Lucy Letby and police officer Wayne Couzins, each from different organisational settings, highlight how the voices of concerned colleagues can be stifled, ignored, or overtly silenced, leading to tragic consequences [51,61]. Both were able to commit crimes due to the trust placed in them by the public and their perceived level of power despite colleagues voicing serious concerns to their supervisors. These cases highlight the catastrophic cost of the organisations failure to act.

Giddens' structuration theory provides insights into how systems enable or constrain whistleblowing. Structuration theory emphasises the interplay between organisational structures and individual agency in shaping human behaviour [26]. Regarding whistleblowing, Gidden's theory (1984) suggests that organisational and social structures, such as the organisational hierarchy and reporting mechanisms within systems, including the associated power dynamics and professional norms, influence whistleblowing activity. The interplay of these structures and systems influences the behaviour and choices of individuals within the organisation, including whether to whistleblow. At the same time, whistleblowing can be seen as an agency-driven action. Individuals can challenge and change these established structures through their whistleblowing actions. Whistleblowers exercise their agency by bringing hidden or unethical practices to light, disrupting the norm, and promoting accountability and transparency. The imperative to speak up and expose risk appears to represent the tipping point where whistleblowers act against the structures imposing the status quo. Overall, Giddens's structuration theory and Foucault's theories of power provide frameworks to understand how whistleblowing in healthcare is shaped by social structures whilst acknowledging the agency and transformative potential of individuals who act via whistleblowing. This highlights the dynamic interplay between structures, power, agency, and the whistleblowing processes.

4.1. Strengths and limitations

This scoping review has illuminated the contemporary whistleblowing research from the perspective of the whistleblowers. The review deliberately set broad inclusion criteria due to the limited literature found during preliminary searches, however one limitation is the focus on English language literature. This is a common limitation of reviews published in English, however, in a review with relatively open criteria does likely limit the geographic reach of the review.

The review identified limited formal research, suggesting a gap in knowledge about individual's experiences and the resources available to conduct appropriate investigations. Only eight of 35 captured documents were primary studies. This shortfall in scholarly research suggests a promising avenue for future research. While all documents touched on newborn and maternity services, distinguishing how whistleblowing plays out in the different professional roles in healthcare proved challenging, as nurses, midwives, and doctors were often grouped together in studies. Additionally, determining the type of maternity unit (tertiary, regional) was challenging, potentially impacting reporting lines and organisational culture. Finally, most captured documents focussed upon the UK context. This highlights the prominence that has been given to whistleblowing in the UK due to tragic cases in the public spotlight, however, there needs to be more exploration of this phenomenon in other geographical zones.

5. Conclusions

There is a lack of literature addressing whistleblowing within maternal and newborn care contexts, particularly reporting primary research. The literature that does exist is primarily concentrated in the UK, shedding little light on other geographical locations. The review nevertheless offers valuable insights into hierarchical healthcare systems' structural and power dynamics, shedding light on factors influencing whistleblowing. The literature gives impetus to developing measures to improve opportunities for the voices of healthcare professionals and consumers to be heard. The emotional and physical toll that experiencing bullying, ostracism, and blame takes, combined with structural issues such as insufficient governance and reporting mechanisms is significant, demanding a response from healthcare organisations. Whilst the cost of whistleblowing is high and often carried by the individual, the cost of silence is equally concerning and borne by the public.

Author contributions

TC: Concept development; Screening of articles; data extraction; data analysis; manuscript development and final approval. BF: Concept development; Screening of articles; data extraction; data analysis; manuscript development and final approval. OM: Screening of articles; data analysis; manuscript development and final approval.

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Ethical Statement

An ethical statement does not apply to this study.

Declaration of Competing Interest

The authors declare no conflict of interest.

Acknowledgment

Nil.

Appendix 1. Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	**Page 1**
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	**Page 1**
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	**Page 4**
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	**Page 4**
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	**N/A**
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status) and provide a rationale.	**Page 5**
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	**Page 5**
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	**Pages 5–6 and Appendix II**
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	**Pages 5, 6 and 7**
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	**Pages 9–15**
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	**Page 6 and 9–15**
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	**N/A**
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	**Page 9**
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	**Page 8 (Fig. 1.)**
Characteristics of sources of evidence	5	For each source of evidence, present characteristics for which data were charted and provide the citations.	**Pages 9–15**
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	**N/A**
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	**Pages 9–15**
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	**Pages 16–22**
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	**Pages 22–26**
Limitations	20	Discuss the limitations of the scoping review process.	**Page 26**
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	**Page 27**
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	**Page 27**

Appendix 2. Database Search Example

01 Jan 2013–31 Oct 2023

Database	Search Terms(All Text)
Embase (n=30)	[midwi* **OR** 'nurs* **OR** medic* **OR** 'healthcare profess*' **OR** 'healthcare work*'] **AND** [matern* **OR** obstetric* **OR** birth*] **AND** [service* **OR** car* **OR** unit*] **AND** ['complain*' **OR** 'concern*' **OR** 'whistleblow*' **OR** 'Speak* up' **OR** 'notif*' **OR** 'disclos*' **OR** 'voic*'] **AND** ['poor practice*' **OR** 'unsafe practice*' **OR** 'dangerous practice*' **OR** 'high risk' **OR** 'harm* practice*' **OR** 'malpractice' **OR** 'negligence' **OR** 'litigat*' **OR** 'misconduct' **OR** 'patient safe*' **OR** 'adverse outcome*' **OR** 'patient risk*' **OR** 'unsafe care' **OR** 'safety concern*' **OR** '*ethical practice' **OR** 'professional mistake*' **OR** 'professional error*' **OR** 'clinical error*']

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