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Mothers' experiences of mistreatment during childbirth – A qualitative analysis of patient insurance claims in Finland

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ABSTRACT

Background: Mistreatment during childbirth by healthcare professionals is a recognized global issue, yet evidence from formal reporting systems such as patient insurance claims in high-income settings like Finland remains limited.
Aim: To describe mothers' experiences of mistreatment during childbirth in Finland as documented in patient insurance claims submitted to the Patient Insurance Centre.
Methods: This qualitative descriptive study analyzed 48 obstetric patient insurance claims in which mothers reported mistreatment during childbirth between 2012 and 2022. None of these claims resulted in compensation. In these claims, mothers provided self-authored narratives describing mistreatment as a contributing factor to the alleged patient injury. Data were analyzed using inductive content analysis. Background variables were summarized descriptively.
Findings: The unifying category, "Disrespectful maternity care and the violation of personhood," encompassed two forms of mistreatment identified in the claims: disrespectful and controlling staff behavior and objectification and dismissal. Most mothers reported psychological harm, while some also described physical injuries such as perineal tears and infections attributed to mistreatment.
Discussion: Mistreatment emerged as a concern within a high-performing health system, with mothers describing disrespectful maternity care that they perceived as violating their personhood. Mistreatment alone is not compensable without a legally defined patient injury. This gap highlights the need for mechanisms that better address relational and emotional harm in maternity care.
Conclusion: Mistreatment should be recognized as a quality-of-care issue, and systemic efforts, including education and organizational support, are needed to ensure respectful, supportive, and safe childbirth experiences for all mothers.

Introduction

The World Health Organization (WHO) emphasizes that high-quality maternity care must address not only the clinical management of childbirth but also the psychological and emotional needs of women across the continuum of perinatal care. A positive childbirth experience defined as giving birth to a healthy baby in a safe, respectful, and supportive environment is a key indicator of high-quality maternity care that integrates clinical safety with respectful, person-centred support (World Health Organization 2018). However, growing evidence (Mirzania et al., 2023; Bohren et al., 2015) indicates that many mothers experience mistreatment during childbirth, including disrespect and neglect, thereby undermining WHO standards for safe, respectful, and dignified maternity care. Mistreatment during childbirth refers to behaviours that violate women's dignity, autonomy, and emotional safety. This includes verbal or non-verbal actions perceived as disrespectful or intrusive, breaches of privacy or cultural expectations, physical abuse, and non-consensual procedures such as episiotomies or caesarean

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sections undertaken without informed consent (Ayres-de-Campos et al., 2024; Bohren et al., 2019; Liu et al., 2024). Despite evidence showing that obstetric mistreatment affects nearly half of women in high-income countries (Fraser et al., 2025), the phenomenon remains underexplored in these contexts, particularly in Nordic countries. Recent work by Mirzania et al. (2023) shows that women's experiences of mistreatment during childbirth remain insufficiently studied, even in well-resourced maternity care systems. This gap limits our understanding of how mistreatment is experienced and how such experiences are formally reported, including through patient complaints and insurance claims.

Mistreatment can manifest in multiple ways within maternity care settings. Experiences related to mistreatment can arise in direct interactions between healthcare providers and mothers, but also through systemic failures at the facility or health system level. Mistreatment may take the form of verbal abuse, stigma, discrimination, neglect, denial of pain relief, or poor communication. Structural issues such as understaffing, inadequate resources, or restrictive policies can further contribute to these harms (Bohren et al., 2015; Kasaye et al., 2024; Mirzania et al., 2023). These practices are increasingly recognized under the concept of obstetric violence, a form of gender-based abuse that violates women's rights during reproductive care and reflects broader power imbalances in clinical settings (Van der Waal et al., 2023).

In Finland, nearly all births (99.2 %) take place in hospitals, which have been consolidated over the past two decades from 31 to 21 birth units. There are currently no midwife-led birth units, and home births remain rare, although their number has slightly increased in recent years (Official Statistics of Finland, 2023). Although women in Finland generally report positive childbirth experiences (Place et al., 2023), instances of mistreatment by health professionals have also been documented. Recent research has shed light on the lived experiences of obstetric violence in Finland, revealing that birthing women may encounter mistreatment in the form of being ignored, manipulated, or subjected to verbal or physical aggression by healthcare staff (Westergård et al., 2025). These negative experiences were contrasted with instances of nurturing care, characterized by compassion, professionalism, and responsible communication, which were found to protect the dignity of birthing women and support their active participation in care. These findings underscore the critical importance of ensuring respectful, person-centered maternity care. Yet in Finland, this mistreatment during childbirth has received limited scholarly attention, and there is a need for more nuanced research into how mothers interpret and describe perceived mistreatment by healthcare professionals in institutional maternity care settings.

The Patient Insurance Center (PIC) in Finland administers all healthcare-related claims under a no-fault compensation model. Claims are filed when deviations or errors in care occur, with patients seeking clarification and possible financial compensation. All patients treated in Finland have the option of filing a claim with the PIC within three years of becoming aware of a suspected injury. The PIC is responsible for registering the claim, collecting medical records, and consulting medical experts to assess whether substandard care occurred. As delineated by the Patient Insurance Act, compensation is granted under the condition that there is a probable causal link between the care and the injury. In the event of a favorable ruling, the patient is entitled to remuneration for any additional expenses and losses incurred as a result of the injury. (The Finnish Patient Insurance Centre, 2025) This is the first study to assess mistreatment in childbirth through patient insurance claims in Finland. To our knowledge, it remains unclear whether any cases of mistreatment in childbirth have resulted in compensation before.

This study aimed to describe mothers' experiences of mistreatment by health professionals during childbirth, as reported in patient insurance claims submitted to the PIC in Finland between 2012 and 2022.

Methods

This descriptive qualitative study is a secondary analysis of obstetric insurance claims filed with the Patient Insurance Centre (PIC) in Finland between 2012 and 2022. The original dataset comprised 849 patient insurance claims seeking financial compensation for injuries attributed to substandard obstetric care, of which 224 (26.4 %) were compensated. Relative to all births in Finland during the study period, the overall claim rate was 0.15 % and the compensation rate was 0.04 %. A detailed description of the dataset is available in a previous publication (Lojander et al., 2024).

The present analysis focused on 48 (5.7 %) uncompensated claims in which mothers reported injuries perceived to have resulted from mistreatment by health professionals during childbirth, including the immediate postnatal period in hospital. The study analyzed written 'notice of injury' documents, each comprising a free-text narrative in which mothers described perceived mistreatment motivating their compensation claim. Mistreatment was defined as any description of verbal or physical abuse, discrimination, neglect, inadequate communication, non-dignified care, or care provided without consent by healthcare professionals during childbirth or the immediate postnatal hospital period. These cases were identified and categorized as "mistreatment" during the initial screening of all claims for a previous study (2024), and this same subset was used for the analysis in the current study. Additional variables extracted from the claims included maternal age, mode of childbirth, hospital size, year of childbirth, and the type of injury mothers perceived to have resulted from the mistreatment.

Ethics

The permission to access the data was gained in March 2025 from the PIC. Under the guidelines of the Finnish National Advisory Board on Research Integrity, the use of pre-existing anonymous registry data does not require approval from the National Committee on Research Ethics (Finnish National Board on Research Integrity (TENK) 2019).

Data analysis

The data were analyzed with qualitative inductive content analysis followed by Graneheim & Lundman (Graneheim and Lundman, 2004) and Vaismoradi (Vaismoradi and Snelgrove, 2016). Descriptive statistics were employed to outline the characteristics of the claims. The length of the original descriptions of mistreatment during childbirth varied widely from a few words to several pages. In the initial phase, the data were read thoroughly and meaning units (words, phrases and conceptual wholes) describing mistreatment were highlighted. The data comprised 10 pages of meaning units extracted from claims submitted to the PIC. These were then condensed and coded to identify key elements, domains, and dimensions of the phenomenon. The analysis yielded 129 codes, which were grouped based on similarities and differences into sub-categories, which were further organized into main categories. A unifying category was developed to illustrate the overarching dimensions of mistreatment in childbirth. The analysis was conducted as an iterative process involving continuous movement between coding, categorization, and the original narratives. Initially carried out by the first author, the process was then reviewed and refined through collaborative discussions with the research team to ensure consistency and agreement in interpretation. (See Supplementary Table 1 for an example of the analysis process.)

Results

Background characteristics

The mean age of the mothers was 30 years, with a range from 18 to 41 years. Most of the mothers (75.0 %) had either a vacuum-assisted birth (n = 18, 37.5 %) or a caesarean birth (n = 18, 37.5 %). Half of the mothers (n = 26, 54.2 %) gave birth in a maternity hospital with

more than 3000 births annually. The annual number of claims ranged from 2 to 7 per year, with the highest numbers reported in 2019 and 2020 (Table 1).

Reported injuries related to mistreatment

In total, 94 mistreatment-related injuries attributed to mistreatment were reported in the claims. The majority were psychological harm (n = 44, 46.8 %), leading conditions such as post-traumatic stress disorder (PTSD), anxiety, and depression, which were self-reported by the mothers. These were followed by reports of pain (n = 16, 17.0 %), perineal tears (n = 10, 10.6 %), and others, e.g., infection, hemorrhage, uterine rupture (n = 24, 25.5 %), which were mothers' own assessments of the consequences related to experienced mistreatment by health professionals (Table 2).

Mothers' experiences of mistreatment during childbirth

The analysis represent the dimensions of experienced mistreatment by health professionals during childbirth, which formed a unifying category "Disrespectful maternity care and the violation of personhood" with two main categories: 1) disrespectful and controlling staff behavior and 2) objectification and dismissal (Table 3). The main categories were then divided into sub-categories describing the phenomenon of experienced mistreatment by health professionals during childbirth in its' various manifestations.

Disrespectful and controlling staff behavior

This category illustrates how birthing mothers experienced psychological harm through shaming, humiliating, and controlling behavior by healthcare professionals during childbirth. These experiences were marked by a lack of respect for the mother's dignity, privacy, and emotional well-being.

Shaming and humiliating treatment during care

Mothers described situations where their bodies were unnecessarily exposed in front of familiar colleagues working in the same unit as the mother, intensifying feelings of embarrassment and vulnerability. Some mothers also reported privacy violations, such as suturing performed in shared recovery areas or intimate procedures, such as stimulating the baby, in positions that made them feel physically and emotionally exposed. These experiences were described as traumatic, with lasting psychological effects, including recurring nightmares and associations with sexual violence.

"The baby was stimulated by massaging his head, so I leaned on the bed with my buttocks upright while the midwife massaged the baby's head vaginally. This happened multiple times and appeared as an assault in my dreams every night." ID39

Mothers also reported inappropriate or mocking comments about their physical appearance, such as remarks about pubic hair or body size. Laughter, rude attitudes, and unprofessional wording made the mothers feel belittled and dismissed rather than supported. Comments were described as rude or mocking as the mothers described professionals rejecting them and laughing at them.

"Behind the curtain, the staff were laughing at the abundance of my pubic hair" ID13

Unprofessional conduct extended to irrelevant personal remarks and unsolicited opinions, such as commenting on the baby's large size and upcoming birth as "interesting" because of that, or making sarcastic jokes during labor causing the mother feelings of shame. For example, when a mother asked about the color of the baby's hair, the doctor replied with a sarcastic comment:

"When the baby's head was slightly visible, I asked what colour the hair was. The doctor responded irritably: 'Very green and slimy.' This comment was rude and intentionally offensive – highly unprofessional behavior from an obstetrician." ID2

Fear-based control and guilt-inducing communication during childbirth

In addition to these degrading experiences, mothers also reported being subjected to fear-based control and guilt-inducing communication. Healthcare professionals were described as using harsh language, threats, and aggression during care to control the mothers. One mother recalled that the doctor listed health-related risks in an angry tone during labor and responded rudely to her questions. Some mothers recounted being shouted at during childbirth or pressured into decisions through emotionally charged warnings without a real possibility to choose. Mothers felt that staff reacted defensively to their questions and used offensive language.

"She shouted that if you're not in your place right now, it's impossible to conduct this vaginal examination, and you should go back home!" ID32

Midwives were also described as unfriendly, blaming, and at times

Table 1
Background characteristics of the claims (n = 48).

Characteristic	Mean (SD) or n (%)
Maternal age (years)	
Mean (SD)	30.2 (5.5)
Min – Max	18 – 41
Mode of childbirth	12 (25.0)
Vaginal	18 (37.5)
Vacuum assisted	18 (37.5)
Caesarean	
Hospital size (births per year)	4 (8.3)
< 1000	12 (25.0)
1000 – 1999	6 (12.5)
2000 – 2999	26 (54.2)
> 3000	
Year of the childbirth	2 (4.2)
2012	3 (6.3)
2013	4 (8.3)
2014	5 (10.4)
2015	3 (6.3)
2016	6 (12.5)
2017	4 (8.3)
2018	7 (14.6)
2019	7 (14.6)
2020	5 (10.4)
2021	2 (4.2)
2022	

Table 2
Reported injuries (n = 94) attributed to mistreatment.

Type of injury	n (%)
Psychological harm (e.g., posttraumatic stress disorder, depression, anxiety, fear of childbirth)	44 (46.8)
Pain	16
Perineal tears	(17.0)
Other (e.g., infection, hemorrhage, uterine rupture)	10
	(10.6)
	24
	(25.5)

Table 3
Mother's experiences of mistreatment during childbirth.

Unifying category	DISRESPECTFUL MATERNITY CARE AND THE VIOLATION OF PERSONHOOD	
Main category	Disrespectful and controlling staff behavior	Objectification and dismissal
Sub-category	Shaming and humiliating treatment during care	Being ignored
	Fear-based control and guilt-inducing communication during childbirth	Violation of physical integrity
		Deficiencies in information flow

verbally aggressive. Mothers felt accused rather than cared for, and in some cases, the birthing partner was also subjected to shouting or harshness. One mother described being accused of being discharged too early, even though she had not independently made that decision.

Objectification and dismissal

In this category, mothers described experiences of being treated as objects, whose opinions, wishes or requests were dismissed. Their concerns were not listened to, and they also described uncooperative health professionals, who made decisions without hearing the birthing parents. As a consequence, mothers felt that they were not attended to by the health professionals.

Being ignored

Mothers described experiences of being ignored, such as situations where healthcare professionals ignored their symptoms or concerns about pain or abnormal bleeding. For example, some mothers reported expressing worries about exceptional pain and possible infection that were not taken seriously. Later, based on their understanding, they were diagnosed with endometritis that could have been identified and treated earlier, if their concerns had been acknowledged. Mothers also described situations in which their maternal instinct that something was wrong with the baby was ignored.

" The doctor made a mistake by not examining me, even though I called multiple times and complained about the prolonged lochia."ID33

Mothers reported that their embodied experiences concerning the pain were neglected, dismissed, or underestimated during labor. One mother described how the local anesthesia did not help and suturing the perineal area hurt. The mother asked several times the midwife to stop, but she said it had to be done.

"I shout to stop; the pain is absolutely unbearable. The nurse rolls her eyes and remarks, 'Oh dear, this is something that has to be done'." ID39

Several mothers stated that they or their partners felt unheard in various situations during birth. They also described not being listened to regarding decisions about their own or their baby's care. Their opinions were neither sought nor acknowledged but simply dismissed. Mothers described feeling like outsiders at the birth of their own child. They reported that healthcare professionals spoke about them as if they were not present.

"Throughout the entire labor, I felt like an outsider during the birth of my own child. The doctor mainly communicated with the staff and did not openly inform me about what they were about to do or were doing at any given time." ID36

According to the mothers, the staff did not always follow their care or birthing plans including their wishes regarding birth and treatment preferences, such as birthing position or pain medication.

"I only hope that my wishes were heard, and that the epidural wasn't pushed on me—at least not as early as it was, since I was still tolerating the pain quite well at that time." ID45

Some requests, such as limiting the number of staff present at birth or excluding students, were ignored. One mother's request to come to the hospital was denied, even though she felt significant pain, but she was told to stay home as long as possible. Another mother described asking every healthcare professional to be gentle during examinations, but most ignored her request. In another case, the mother described how the midwife appeared to believe that the birth should be medication-free, and the mother's wishes were disregarded because of the midwife's views.

"The experience was terrible all around, and no one seemed to care at all about what I was hoping for." ID46

Mothers described dismissive behavior, where healthcare professionals showed little interest in their condition, failed to ask about their wellbeing, or did not acknowledge exhaustion or panic attacks during birth. Mothers felt alone and alienated during a significant life event, as their experiences were overshadowed by professional dominance. One mother described that she was left with deep trauma, and I didn't believe she would ever be able to give birth again or even consider getting pregnant.

"On the ward, I felt insecure, with fears of childbirth and death. My condition was not asked about even once after the birth while I was in the ward." ID37

Mothers reported that midwives often left the birthing room without checking how they were coping, even when the mothers were worried that the birth was not progressing. Fear of not receiving proper care or any help at all was commonly experienced. One mother described being in such poor condition after birth that she could neither stand nor lie down, sitting on the side of the bed and ringing the bell repeatedly for help to reach her newborn. She waited for three hours before anyone came and felt completely abandoned.

"We waited to see when someone would come, but according to my experience, they didn't. It felt like torture that help was not available." ID45

Mothers felt that healthcare professionals showed little emotional support, leaving them feeling confused, vulnerable, and neglected. The system was perceived as lacking empathy and trustworthiness. One mother described how she received no help or guidance during the pushing phase, even though she was a first-time mother and began pushing on her own without support from the midwife.

"I did not receive the necessary support, explanation, or reassurance from the attending midwife during childbirth." ID8

Fear of childbirth was also not acknowledged, as some mothers said their fear was dismissed. In one case, the designated support person was excluded from the birthing room, even though their presence had been emphasized in the birth plan due to severe fear of childbirth. Some mothers experienced being forced into a vaginal birth instead of a cesarean section. One mother, who had a documented fear of childbirth and was afraid of pain, said her wish for complete pain relief was overlooked, which she found traumatic.

"I am applying for compensation regarding the neglect of diagnosed fear of childbirth concerning my son's delivery." ID34

Violation of physical integrity

Mothers described experiences that they perceived as violations of their physical integrity. They reported rough treatment during external and internal examinations and harsh physical handling during childbirth, such as being forcibly repositioned on the birthing bed.

"I have never been handled so roughly in my life as I was during childbirth." ID36

Mothers described being held down during examinations or the pushing phase, which they experienced as traumatic and violent. Some reported undergoing procedures such as episiotomy, spinal or epidural anesthesia, and internal examinations without consent or even explanation. Mothers described how these procedures just "happened". They said operations were performed without being informed or asked for permission. Some mothers described these experiences as acts of "pure violence".

"They grabbed me during the next contraction, lifted me onto another bed, and turned me onto my back into a painful position, even though I objected. My arms and legs were held down by four people. I was treated like a psychiatric patient under forced care." ID13

Physical restraint also appeared in the form of being forced to lie in bed against their will or being denied freedom to choose their birthing position. Some mothers were even denied basic assistance with hygiene or mobility, particularly when facing additional challenges such as stoma.

Deficiencies in information flow

This category included the mothers' experiences of not receiving enough real-time information about their or their baby's care, as well as inadequate information from healthcare professionals for the birthing parents at different phases of birth. Some mothers described not

receiving adequate breastfeeding support or clear instructions for physical recovery at hospital discharge.

Mothers said they did not receive sufficient information about key aspects of their care, such as the progress of birth, administered medications, or their own and their baby's health. In some cases, partners were excluded from important discussions.

"The course of the childbirth was not discussed with me or my partner at all. I did not receive sufficient information about the progress of the birth, the baby's actual condition, or the different possible options for how the birth could proceed."ID34

Mothers lacked information from healthcare professionals. One mother described how language barriers among healthcare staff led to misunderstandings and feelings of insecurity, because the mother did not understand what was going on. Others said information was withheld or even mispresented, such as not being told about a cervical tear sustained during birth or misinformation about the conducted episiotomy.

"The midwife lied about performing only a grade I episiotomy, saying she would cut only the skin, even though she actually performed a normal grade II episiotomy" ID2

Another mother expressed disappointment that, contrary to what had been promised during antenatal care, the midwives did not inform about different options during childbirth.

Discussion

This study is the first to examine how mistreatment during childbirth is described in patient insurance claims submitted to the PIC in Finland. By analyzing mothers' narratives, two key categories of mistreatment were identified, including disrespectful and controlling staff behavior and objectification and dismissal. These findings do not align with the World Health Organization's (WHO) quality framework, which highlights the importance of care that is respectful, including dignity, communication, and emotional support (World Health Organization, 2018). This suggests that even medically well-performing systems can have problems with providing respectful maternity care. Despite Finland's strong maternal health outcomes, such as low maternal and infant mortality rates (Official Statistics of Finland, 2023), these findings highlight the need to acknowledge and address mistreatment as a threat to quality and respectful maternity care.

In this study, mothers described disrespectful and controlling staff behavior, which caused emotional harm, that could in some cases lead to posttraumatic stress disorder, depression, anxiety and fear of childbirth. Emotional and verbal abuse have been shown to be the most frequent types of experienced mistreatment during childbirth (Galle et al., 2025). Our finding is supported by previous research stating that women who experience mistreatment during childbirth were at higher risk for postpartum depression symptoms (Paiz et al., 2022). Negative birth experience can also lead to postpartum depression and other mental health conditions, as well as fear of childbirth (Henriksen et al., 2017; Shorey et al., 2018), which emphasizes the importance of improving the quality of care during birth. Experiences of mistreatment ranging from inadequate communication and emotional neglect to more overt forms of verbal or physical abuse can significantly impact maternal well-being and trust in the healthcare system (Mirzania et al., 2023; Galle et al., 2025).

Inadequate communication in this study illustrated violations of shared decision-making during childbirth, as mothers described experiences of objectification and dismissal, which contributed significantly to their negative experiences. Healthcare professionals are responsible for making sure women are thoroughly informed, which involves openly sharing information and being transparent about any personal opinions or biases that could affect medical choices. When these standards are not maintained, women can feel sidelined and powerless in making decisions about their own care, which can weaken their sense of autonomy and diminish their confidence in the healthcare system (Begley et al., 2019). It has been stated previously that women should be better informed about possible risk factors and the frequency of different birth interventions, which may support mothers to develop evidence-informed expectations of birth and reducing the expectation-experience gap. Being better informed has a consequent impact on maternal postnatal wellbeing (Davies et al., 2024). Shared decision-making is a collaborative process, which involves clinicians and pregnant women jointly choosing a course of action or no intervention (Begley et al., 2019). If providers are unable or unwilling to engage in shared decision-making, women may become passive, leading to lower satisfaction and increased psychological distress during perinatal experiences (Hawke et al., 2022).

Majority of mothers describing experiences of mistreatment during childbirth in this study had experienced either a vacuum-assisted or caesarean birth. Our previous study found that these modes of birth account for a higher proportion of filed and compensated claims in Finland (Lojander et al., 2024). Perceived mistreatment during childbirth has been linked to adverse psychological outcomes and is more frequently reported in the context of interventional births. A recent Spanish study found a strong association between perceived disrespect or abuse during childbirth and postpartum PTSD risk, with women reporting the highest levels of mistreatment showing increased odds of PTSD (Ortiz-Esquinas et al., 2025). Similarly, a large U.S. survey study reported that unplanned caesarean births were associated with higher rates of self-reported mistreatment, including poor communication, lack of consent, and feeling ignored by staff (Liu et al., 2024). Together, these findings suggest that interventional or unplanned modes of birth, such as emergency caesarean or instrumental deliveries, may heighten mothers' vulnerability to perceived mistreatment, potentially due to the urgency, complexity, and communication challenges inherent in such situations. It has been suggested that better maternity care, adequate pain relief, and support during the birth process could increase childbirth satisfaction (Danish et al., 2025).

Women often turn to midwives for clarification about procedures in case of complications, while they generally expect less detailed explanations from obstetricians, as these doctors mainly focus on managing the complications themselves. It is important to remain aware of the possibility of traumatic experiences. Studies have shown that women who have gone through traumatic events tend to feel less in control during decision-making processes. Therefore, it is vital to talk about potential complications both during prenatal classes and after birth, including the reasons for and the procedures involved in such situations. Explaining what happened can help reduce the risk of developing posttraumatic stress disorder. (Holten and de Miranda, 2016; Murray-Davis et al., 2014; Hollander et al., 2017). According to research by Henriksen et al. (2017), women who had negative birth experiences often felt unprepared for complications and received inadequate care, which made them feel unseen or unheard during labor. This contributed to an overall negative perception of their birth experience. These findings highlight the importance of discussing possible complications, unexpected events, and even life-and-death situations with pregnant women both before and after childbirth. Addressing this in antenatal education is crucial to prevent discrepancies between women's expectations and their actual experiences. (Davies et al., 2024).

Psychological harm was the most reported experience of mistreatment during childbirth by the mothers. PIC only compensates such harm if it meets legal criteria, including objectively demonstrable deterioration in mental health. Feelings of distress or dissatisfaction do not qualify, even if they significantly affect the care experience. This creates a gap between mothers' perception of harm and the legal framework, which prioritizes avoidable clinical injuries over relational or emotional harm. Such differences may lead to feelings of injustice and weaken trust in healthcare institutions. Beyond psychological harm, mothers reported physical injuries, including perineal tears, infections, and other complications, which in their opinion were related to mistreatment. It could be speculated that, since these injuries result from perceived

mistreatment rather than technical medical errors, they may be overlooked and remain uncompensated. Addressing this gap is essential to ensure comprehensive protection and justice for mothers who experience mistreatment during childbirth.

In addition to improving care culture, the current patient insurance system in Finland may also require revision, as it may not adequately recognize or address the critical dimension of psychological safety in childbirth. While physical outcomes are often prioritized, the emotional and psychological well-being of mothers, particularly in cases where mistreatment by healthcare professionals occurs, can be overlooked. This oversight neglects the importance of a positive childbirth experience, which is equally vital to maternal health and recovery. The patient insurance policy system may not reflect the full spectrum of maternal needs, leaving a gap in protection and support for mothers during one of the most vulnerable periods of their lives.

Patient insurance claims represent a valuable resource for improving care quality, enhancing patient safety, and ultimately strengthening maternal and newborn health outcomes, including maternal childbirth experiences. While clinical outcomes are often documented and analyzed, disrespect, neglect, or coercion, are rarely captured in formal complaint systems or compensation processes. In Finland patients have several complaint channels. A patient injury claim is made to seek financial compensation for personal injury. Complaints about inappropriate treatment by professionals are advised to primarily be made directly to the healthcare organization in question. A comprehensive understanding of disrespectful care during childbirth would require combining different data sources, and even then, not all cases would likely to be identified. Previous study from Denmark showed that complaints about obstetric care differ from those in other healthcare services, with higher frequencies and multiple concerns raised per complaint (Walløe et al., 2023). Common issues included a lack of listening, respect, and problems related to the care environment, often attributed to staff shortages. Such patterns suggest a perceived lack of recognition and individualized support in hospital maternity care. Considering these complaint trends may offer important insights for guiding future organizational changes to improve respectful and mother-centered obstetric care (Walløe et al., 2023).

Strengths and limitations

The main strength of this study is its use of a unique national data source spanning a long period: formal patient insurance claims, which offer insight into how mothers describe and legally frame mistreatment during childbirth. This perspective adds depth to survey-based experience measures and clinical records. However, some limitations should be noted. The data were not originally collected for research, and the narratives may be shaped by legal advice, expectations about what qualifies for compensation, and the structure of the claims process. There is selection bias, as only those who believed they were injured and were motivated to file a claim are included, and underreporting is probable. A limitation of the study is that the narratives differed in depth and detail, and the researchers were unable to seek further clarification or elaboration from the mothers. These factors limit how widely the findings can be applied and prevent thorough conclusions about mistreatment during childbirth. Finally, these data reflect only mothers' experiences of mistreatment and exclude healthcare professionals' perspectives, which are essential for fully understanding the phenomenon.

Conclusion

This study demonstrates that mistreatment during childbirth is documented in patient insurance claims in Finland, revealing mothers' experiences of disrespectful and controlling staff behavior and objectification and dismissal. These findings highlight that even in a high-performing maternal health system, mistreatment undermines the quality of care and threatens respectful maternity care. Addressing these issues requires acknowledging mistreatment as a systemic problem and ensuring that dignity, communication, and emotional support are integral to obstetric practice.

CRediT authorship contribution statement

Reeta Lamminpää: Writing – review & editing, Writing – original draft, Validation, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Anna Axelin:** Writing – review & editing, Methodology, Conceptualization. **Marja Härkänen:** Writing – review & editing, Validation, Conceptualization. **Maija Männistö:** Writing – review & editing, Validation, Conceptualization. **Maiju Welling:** Writing – review & editing, Validation, Conceptualization. **Jaana Lojander:** Writing – review & editing, Writing – original draft, Validation, Methodology, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2026.104722.

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