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Exploring the uses of virtues in woman-centred care: A quest, synthesis and reflection

Running title: Woman-centred care virtues

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Abstract

Woman-centred care is a philosophy authentic to the midwifery profession, scaffolding and preceding the capacity and utility of woman-centred care in daily practice. Through providing guidance on the philosophical capacities - the virtues - the practical capacity and utility of woman-centred care becomes more clear and more tangible. This paper discusses virtues of woman-centred care in midwifery practice. Eighteen virtues, described by Compte-Sponville, serve as a philosophical lens to explore and understand how each specific virtue integrates into the woman-centred care concept or vice versa, herewith becoming woman-centred care virtuous acts. The virtues are politeness, fidelity, prudence, temperance, courage, justice, generosity, compassion, mercy, gratitude, humility, simplicity, tolerance, purity, gentleness, good faith, humour and love. Exploring these virtues provides a manageable view of the complexity of woman-centred care. In this paper, first each virtue is discussed in relation to the body of knowledge of woman-centred care in midwifery. Thereafter, a sketch of pragmatism is provided through translating the virtues into practical recommendations for the professional socialisation and transformation of becoming, being and doing woman-centred care.

Key words: ethics of care; midwifery; philosophy; theory-practice; virtues; woman-centred care

1. Introduction

Since long, the word midwife is associated with 'wise woman', which means being entrusted with wisdom in the practicalities of everyday life, being entrusted with emotional intelligence and showing transformational, transactional and servant-leadership in finding answers and in making decisions - while caring for childbearing women. 'Wise woman' means making general and fundamental inquiries about existence, knowledge, values, reason, mind and language in relation to childbearing. Wise woman also means being the holder of particular knowledge and skills - while looking out for the good of childbearing women. The original meaning of the word midwife is 'with woman', shaping the midwife's philosophical thinking about care for childbearing women (Kennedy et al., 2010; Chamberlain et al., 2016). For midwives, philosophy of care is (inter)nationally linked to the code of ethics formulated by the International Confederation of Midwives (ICM) (ICM, 2014; ICM, 2014a). The midwifery code of ethics, integrated in global standards that inform day-to-day midwifery practice, is relevant for strengthening midwives in how to relate to women in their care. The ICM's code of ethics urges midwives to be woman-centred through activities that serve the relationship between each individual woman and midwife (ICM, 2014; ICM, 2014a).

1.1. Woman-centred care

Woman-centred care is a philosophy authentic to midwifery, underpinning and guiding midwifery practice. Woman-centred care is about embracing the woman-midwife relationship, about how midwives are being true to the midwife's identity, to the midwife's unique individual capabilities and potential as a midwife. Woman-centred care is about how the midwife is unconditionally supportive to the woman's control and power during the care process (Leap, 2009; Sherman, 2009; Rigg & Dahlen, 2021). Woman-centred care is defined as:

> …A midwifery philosophy and a consciously chosen tool for the care management of the childbearing woman, where the collaborative relationship between the woman -as an individual human being- and the midwife -as an individual and professional- is shaped through co-humanity and interaction; recognising and respecting one another's respective fields of expertise. Woman-centred care has a dual and equal focus on the woman's individual experience, meaning and manageability of childbearing and childbirth, as well as on health and wellbeing of mother and child… (Fontein-Kuipers et al., 2018, p.8)

Based on midwives' ideations of woman-centred care a hierarchal framework was constructed, constituting three levels of which the midwife's *core philosophy* of woman-centred care constitutes the first level. These levels are also to be recognised in the definition. This first level is essential as the philosophy is the *fundamental belief* or *reasoning* that underpins woman-centred care in midwifery practice – individual (intrinsic or learned) beliefs, ethics, and values – grounding woman-centred care. The midwife's core philosophy drives, scaffolds, dispositions, and guides the next levels of woman-centred care: midwives' woman-centred *actions* and *purpose(s)* (Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019). The second level represents the midwife's actions in the reciprocal interpersonal relation with the woman, the midwife's interpersonal actions towards the woman's partner, family and community and the interpersonal actions between the midwife and other healthcare professionals involved with the woman but also the utilisation of woman-centred care models or organisational strategies (Fontein, 2010; Brady et al., 2017; Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019a; Fontein-Kuipers et al., 2020). The third level comprises what the midwife aims to achieve by providing woman-centred care, for example: healthy outcomes, personal fulfilment, and empowerment of women as well as self-actualisation of themselves as midwives and of the women in their care (Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019; Newton et al., 2021; Sheehy et al., 2021). Although midwives' salient belief is that women-centred care is the core and the identity of the midwifery profession, midwives have articulated to need guidance and help in connecting the philosophy of women-centred care to their practice, as woman-centred care is not the norm in midwifery practice and woman-centred care governance is limited (Fontein-Kuipers et al., 2016; Brady et al., 2019; Fontein-Kuipers et al., 2019; Crepinsek et al., 2021; Rigg & Dahlen, 2021).

As an educator, I challenge and support midwifery students to formulate their core assumption of woman-centred care and encourage them to test 'the midwifery waters' during in-

school education and clinical placements - developing and nurturing their philosophy up to, and beyond the moment of graduation. In dialogue with practising midwives, I have managed to gain understanding of woman-centred care in day-to-day practice through exploring midwives' thoughts, perceptions and their views on and experiences with woman-centred care as well as through observing midwives' (un)spoken language. I have gained insight in what woman-centred care means to midwives, what they believe, what drives and motivates them, what their values are, what they do or don't do, what they aim to achieve and what hinders and what supports them (Fontein-Kuipers et al., 2016; Fontein-Kuipers et al., 2018b; Fontein-Kuipers et al., 2019). I have discovered that women appoint midwives as the most woman-centred care practitioner within maternity services, although women still report unmet needs in terms of woman-centred care (Baas et al., 2017; Fontein-Kuipers et al., 2019a, Petit-Steeghs et al., 2019; Fontein-Kuipers et al., 2021; Fontein-Kuipers & Mestdagh, 2021). Through conducting conceptual and theory forming research I have become aware that midwives relying on a fundamental philosophy to practice in a woman-centred way is pivotal (Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019). The woman-centred care concept has an ordered structure with the philosophy serving as the foundation of becoming or being a woman-centred care midwife, implying that a core philosophy of woman-centred care is an antecedent for its capacity and utility (Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019). Knowing that the philosophy of woman-centred care plays such a fundamental and crucial role in midwives' actualisation of woman-centred care and being aware that (student) midwives are more practitioners rather than philosophers, I hypothesised that if I would be able to provide guidance on the philosophy, the practical capacity and utility of woman-centred care might become more clear and more tangible. With examples for practice, I even might be able to make it more realistic and feasible.

1.2. "A small treatise on the great virtues"

Coming across Comte-Sponville's book (2002), "A small treatise on the great virtues", I was struck by one of the very first sentences in the book where he explained that the point of a treatise of virtues is "trying to understand what we should do, what we should be, and what separates us from our ideals or desires" (p.3). As for me this so very much represents the nature of the philosophical level and fundament of woman-centred care, I decided to go on a quest for woman-centred care wisdom, engaging in the qualities of midwives in *being*, *doing* and *becoming* woman centred (Näsman & Nyholm, 2020). Eighteen chapters, each describing, discussing, and reflecting on a particular virtue, referring to and weaving together the work of philosophers such as Aristotle, Kant, Nietzsche, Montaigne, Alain, Descartes, Schopenhauer, Jankélévitch and Weil. Comte-Sponville (2002, p.5) states that by making the work of others our own and by transforming it, becoming it, and using the thoughts of others, you can formulate your own thoughts with the means available. Embracing this notion, I synthesised each virtue, transforming it into a *woman-centred care virtue* and into *woman-centred care virtue acts*. In the face of the richness of the woman-centred care body of knowledge, I highlighted the sentences in the book that resonated with woman-centred care. Realising my subjective course of action, I checked the literature to validate my thoughts and when showing to being a genuine contribution, I linked the virtue to woman-centred care and to practice examples. All virtues and their related woman-centred care virtues and virtue acts, that derived from the literature, were organised in a matrix (Excel©), serving as a guide to writing this paper. Being an expert of woman-centred care but by no means being a philosopher, this was quite an exertion, but being a meaningful and useful one – as this allowed me to affirm the foundation, and to translate the content meaning, of woman-centred care for midwifery practice. This paper is written with the midwife in mind as woman-centred care is authentic for midwives who are lead-carers of childbirth (Lee Davis & Walker, 2011). However, as woman-centred care derives from concepts such as person-centred, patient-centred and family-centred care, this paper might be transferable to other healthcare domains. The virtues described by Comte-Sponville (2002) serve as a framework to contribute to an understanding of the substance of philosophical virtues, in order to provide midwives with a perspective on the concept of woman-

centred care and in *becoming*, *being* and *doing* woman-centred (care). Moreover, all humans possess virtues, allowing midwives to recognise themselves to a more or lesser degree in the virtues (Hursthouse & Pettigrove, 2018). As I regard Comte-Sponville much more of an expert than myself, I rely on his completeness of the virtues. I might have missed important literature and therefore the described woman-centred care virtue acts might not be complete, for which I do apologise. Comte-Sponville (2002, p.2) states that the words used to describe the virtues might sound historical. However, as Comte-Sponville refers to fundamental philosophers I have chosen to use the traditional terms. By using contemporary (western) woman-centred care literature, to examine the meaning of virtues in detail, the virtues that may sound 'old-fashioned' will fit into current midwifery care.

2. The 18 virtues

2.1. Politeness

Comte-Sponville (2002) describes politeness as a foundation for the moral development of the individual - a virtue of etiquette - complying with definitions, obligations, frameworks and rules, necessary to grow and develop. Politeness precedes the internalisation of morality through education, adherence to a code of duties and through imitation. "Politeness is a small thing that paves the way for great things" (Comte-Sponville, 2002, p.14). Politeness is a relevant virtue for woman-centred care as the concept is often not being embraced immediately or implemented in its full form by (student) midwives when being introduced or implemented, despite the recognition for its benefits for women (Fontein-Kuipers et al., 2016; Brady et al., 2017; Fontein-Kuipers & Romeijn, 2018; Fontein-Kuipers et al., 2019; Rigg & Dahlen, 2021). Politeness facilitates the learning of how to be(come) a woman-centred midwife and in embedding doing woman-centred care. Education, reflection on and discussions about woman-centred care, having role models, adopting a woman-centred care code of conduct and making an effort in exploring woman-centred care strategies and care models - all serve as politeness in woman-centred care (Lake, 2014; O'Malley-Keighran & Lohan, 2016). Woman-centred care is an emancipatory movement, and the concept has been included in a range of policy documents at international and national levels since the 1990s, notably in the United Kingdom (Cumberlege, 2016, Grant, 2017) and in Australia (Commonwealth of Australia, 2011). The woman-centred care movement implies that we do not have to start anew: listen to the experts, watch the role models that have emerged over time and read the evidence (to start with the references in this paper).

2.2. Fidelity

In fidelity lies the true basis of personal identity through feeling responsible, being loyal and being committed to certain ideas. Fidelity is a virtue associated with will, intention, and choice (Comte-Sponville, 2002). To remain faithful to the woman-centred care concept and its utility, midwives must be constantly and consciously aware of the worth of woman-centred care (Fahy, 2012). With respect to fidelity, it is of essence to know and understand the meaning and the comprehensibility of woman-centred care, the outcomes and advantages and to own a sense of woman-centred care self-efficacy and behavioural capability (Lee, 2004). Fidelity of thought requires valid reasons (Comte-Sponville, 2002). Ongoing woman-centred care research and being up to date with woman-centred care evidence is therefore an important mean for midwives to be and to remain committed to woman-centred care. The definition of woman-centred care recognises that having and committing to a core philosophy is a prerequisite to be loyal and faithful to woman-centred care, at least on an intradisciplinary midwifery practice, clinic or ward level (Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019). Without being faithful to the core philosophy, midwives are not going to be able to hold on to, and act in line with midwives' values and integrity - during really difficult times or when being challenged. Fidelity asks the midwife to fully understand, strongly believe in, and to be totally committed to the woman-centred care concept and philosophy (Sherman, 2009).

2.3. Prudence

"Prudence is practical wisdom, wisdom of action for action, in action" (Comte-Sponville, 2002, p.33), referring to the utility of woman-centred care as a result of finding and committing to one's philosophy

(Fontein-Kuipers et al., 2018). Prudence is enlisted to serve ends and is concerned with the choice of means that connects the midwife's core assumption with the midwife's purpose. An example is the midwife who approaches woman-centred care from a human-rights perspective, who deliberately chooses to act as the woman's advocate and who actively supports the woman to determine if, how and to what extend the woman wants to self-manage and participate in her own care process, aiming to empower her and to make sure the woman's choices and decisions are met (Fontein-Kuipers et al., 2019; Fontein-Kuipers et al., 2019a). Prudence acts as the midwife's protecting and advising virtue - "Do no harm" (Comte-Sponville, 2002, p.36) - a phrase recognisable for midwives; a humanistic disposition that makes it possible to deliberate on what is wise and what is not. In woman-centred care 'do no harm' is represented by equally protecting the woman's individual experience of childbearing as well as maternal physical and emotional health and wellbeing (Fontein-Kuipers et al., 2018). Prudence is a governing virtue, suggesting that an agent would be of merit to arrive at pragmatism. An agent who leads, generates meaning, who casts light on woman-centred care points of view and actions, who shifts the direction of ideas in maternity services and who safeguards the essence and importance of woman-centred care (Deering et al., 2020; McInnes et al., 2020).

2.4. Temperance

Temperance is about fulfilment, being the master of experiencing pleasure, being happy, satisfied and content in what you do on a regular, rather than on an exceptional basis (Comte-Sponville, 2002). An example is the midwife who manages a good balance between the wishes of women, her own heart and mind, own knowledge and expertise, work and private life, and a balance between her personal and professional responsibilities and ambitions (Fontein-Kuipers et al., 2019). Temperance is about preferring quality to quantity, intensive rather than extensive (Comte-Sponville, 2002). A midwifery practice consisting of one or two midwives holding a small caseload and working according to a continuity of midwifery care model, has been recognised as a woman-centred care strategy (Fontein, 2010; Fontein-Kuipers et al., 2021). Care models where 'less is more' are known for high levels of midwives' satisfaction and wellbeing (Newton et al., 2014; Fenwick et al., 2018). When a smaller sized practice or continuity of care(r) is not feasible, the midwife can make changes in the existing practice organisation, such as by extending time of antenatal and postnatal checks, reorganising in smaller teams of midwives, or offering direct-woman related (social) activities (Fontein, 2010; Fontein-Kuipers et al., 2019; Kuipers et al., 2019).

2.5. Courage

Courage is the capacity to stand up to, confront, master and overcome fear through knowledge, expertise, will and opinion. The extent of the midwife's courage is often in proportion with the beliefs and the boundaries of woman-centred care that the midwife establishes for herself (Lyckestam Thelin et al., 2014; Fontein-Kuipers et al., 2016; Fontein-Kuipers et al., 2018). Examples for setting woman-centred care boundaries are being or feeling threatened or being coerced in being involved or in performing irresponsible, unnecessary or inhumane interventions or actions that violate personal, human and/or ethical standards (Fontein-Kuipers et al., 2018b; Fontein-Kuipers et al., 2019). By standing up for and voicing own moral values and/or the woman's (human/reproductive) rights and choices, the midwife shows courage (Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019; Jefford et al., 2021). The midwife shows courage by accepting that midwife colleagues or obstetricians criticise her practice or disagree with her actions and that legislation is part of the job (Burau & Overgaard, 2015; Fontein-Kuipers et al., 2018b; Fontein-Kuipers et al., 2019). Practising in a woman-centred way requires courage, because woman-centred care is not regarded as the norm (Fontein-Kuipers et al., 2016; Fontein-Kuipers et al., 2019; Crepinsek et al., 2021; Rigg & Dahlen, 2021). Sharing the same woman-centred care vision and practices with colleague midwives, is known to strengthen courage (Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019).

2.6. Justice

Justice is the virtue of equality and reciprocity. In the woman-centred care woman-midwife relationship there is recognition for the dynamic interchange of the woman's experiential or embodied knowledge

and the midwife's professional knowledge - in the exchange in decision making and decision authority (Maputle & Hiss, 2013; Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2021; Fontein-Kuipers & Mestdagh, 2021). Justice is the virtue that leads each person to try to overcome the temptation to place him/herself above everything or someone else (Comte-Sponville, 2002) by simply, not taking advantage of the woman's lack of or limited knowledge, her lack of or limited power, confusion, inconvenience or taking advantage of the woman's needs and vulnerability (Fontein-Kuipers & Mestdagh, 2021). Justice is shown by making professional interest or the interest of the organisation, protocols and guidelines subordinate to the woman's interests (Leap, 2009; Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2018b; Jefford et al., 2021; Rigg & Dahlen, 2021). Additionally, justice is evident when not making the woman's psychosocial or emotional needs subordinate to her physical and/or medical needs and by mutually agreeing about the responsibilities of both the midwife as of the woman (Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019). The essence of justice in woman-centred care is freedom, dignity of the individual, human-rights and consent (ICM, 2014; Fontein-Kuipers et al., 2019; Rigg & Dahlen, 2021). Freedom and equality are to be found in politics around vulnerability in pregnancy (Kuipers & Mestdagh, 2021).

2.7. Generosity

Generosity is the virtue of sharing, an affirmation of cohesion, interdependence, a collective destiny and/or common interest. Examples are establishing a joint goal between the woman and the midwife and sharing similar viewpoints of woman-centred care with colleagues (Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019). In woman-centred care, generosity is found in transferring knowledge, expertise, control, confidence, self-esteem on the woman-midwife interpersonal action level (Fahy, 2012; Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019; Fontein-Kuipers et al., 2019a; Fontein-Kuipers et al., 2021). Midwives sometimes voice that they do not need or want to be best friends with the women in their care (Fontein-Kuipers et al., 2016; Fontein-Kuipers et al., 2019). Generosity facilitates midwives - even in the absence of friendship - to give women what they need aiming at the advantage of the woman, guided by proximity (Fontein-Kuipers et al., 2019). Friendship is, therefore, not a requisite for woman-centred care, but companionship is (Comte-Sponville, 2002; Lyckestam Thelin et al., 2014).

2.8. Compassion

Compassion is fellow-feeling and pure acceptance of the lived-experience of the other person, without contempt, reservation, or pity (Comte-Sponville, 2002). Compassion is reactive and protective and is present in the midwife who chooses to act as the woman's advocate (Fontein-Kuipers et al., 2019; Rigg & Dahlen, 2021). Compassion involves sensitivity, attentiveness, openness, patience, respect, listening, solicitude and solidarity (Lyckestam Thelin et al., 2014). According to Comte-Sponville (2002) 'humanity' best describes compassion. A Q-methodology study appointed the humane midwife - who respects freedom of choice, individuality and authenticity of both woman and midwife – to represent the dominant and preferable perspective of woman-centred care (Fontein-Kuipers et al., 2019).

2.9. Mercy

Mercy in woman-centred care is concerned with understanding the midwife's actions as a (multidisciplinary) practitioner, as well as understanding the actions of childbearing women (Comte-Sponville, 2002). Woman-centred care is grounded in a biopsychosocial opposed to a medical model, perspective and approach (Fontein-Kuipers et al., 2018). Midwives may experience conflicting values in partnership with the woman, feeling torn between being either loyal to the woman or to oneself, when simultaneously being a team player in a multidisciplinary childbirth domain (Thompson, 2013; Fontein-Kuipers et al., 2018b). Mercy requires that we dismiss passion or fanaticism (Comte-Sponville, 2002), which implies that midwives, obstetricians and women should not try to convince each other of who or who's perspective (i.e. medical *vs* biopsychosocial model) is right or wrong, good or bad (Fontein-Kuipers et al., 2018). A professional cultural where individual practitioners feel safe, accepting and respecting the shared and unique professional norms, standards and values and the autonomy of the different practitioners, will help to establish positive intra and/or multidisciplinary dynamics, facilitating

mercy (Clemons et al., 2019; Cronie et al., 2019). Communicating with women as well as with colleagues on an intradisciplinary and/or multidisciplinary level about doubts and regrets regarding decisions, wrongdoing, mistakes and/or (unnecessary) interventions - asking for understanding - allows mercy upon ourselves.

2.10. Gratitude

Gratitude is "the ability to give back but also being happy for the happiness we are been given" (Comte-Sponville, 2002, p.134). Childbearing women make midwifery possible, knowing that the midwife is an effect of woman-centred care and not a cause (Comte-Sponville, 2002). As midwives we are part of childbirth and the process and transition of be(com)ing a mother - one of the woman's most profound life-events. Midwives have the privilege of being invited into women's lives (Lyckestam Thelin et al., 2014). Woman-centred care recognises that it is the woman who comes to seek the midwife to join and rejoice in what takes place and not the other way around (Fontein-Kuipers et al., 2019). As a midwife you can only act when a woman confides and shares her personal thoughts, her values and needs, when she allows to be physically and intimately touched – thus sharing her vulnerability – which is quite an honouring and humbling act (Lyckestam Thelin et al., 2014; Fontein-Kuipers et al., 2019). Therefore, the midwife should ask the woman consent to ask sensitive questions, for each palpation, (internal) examination, for checking the woman's blood pressure or the baby's heartbeat; for everything that involves touching the woman, intervening with her integrity or for sharing the woman's personal information with other healthcare professionals (Fontein-Kuipers et al., 2019).

2.11. Humility

Humility is the recognition that midwives do not give life and that women are not in debt to midwives. This is best reflected in respecting the well-known quote: "You are a midwife, assisting at someone else's birth. Do good without show or fuss. Facilitate what is happening rather than what you think ought to be happening. If you must take the lead, lead so that the mother is helped, yet still free and in charge. When the baby is born, the mother will rightly say, "We did it ourselves!" (Tao Te, Ching, Lao Tsu 5th century B.C.). In other words, do not take credits for whatever happens (Chamberlain et al., 2016). Humility shows when using woman-empowering language in conversation with women or other healthcare professionals as well as in documents of professional bodies (Hunter, 2006; O'Malley-Keighran & Lohan, 2016; Brady et al., 2019; Crepinsek et al., 2021).

2.12. Simplicity

Woman-centred care is complex and deeply epistemological, multi-dimensional, qualitative, contextual and rather complex (Fontein-Kuipers et al., 2018) - a description that most definitely does not represent simplicity. The simplicity of woman-centred care is therefore probably best captured by Fleming (1998), who describes woman-centred care as being with women through a relationship centred in 'being'. This has been described as the 'being approach' rather than the 'doing approach' during birth, which means just being present, minimising examination, palpation, auscultation or checking maternal vital signs (Fleming, 1998; Nilsson et al., 2019). "Such is the simple person: a real individual, reduced to his simplest expression" (Comte-Sponville, 2002, p.149).

2.13. Tolerance

The virtue of tolerance becomes apparent in matters of different opinions and different truths or conflicts between the woman's and the midwife's levels of control and autonomy (Fontein-Kuipers et al., 2018). An ultimate example of tolerance is the woman who make choices that fall out of the realms of accepted policies and guidelines, when the midwife cannot impose her truth on the woman, or vice versa - as tolerance is the virtue that stands counter to authoritarianism (Thompson, 2013; Fontein-Kuipers et al., 2019). In woman-centred care, the role and interests of the (unborn) child are not clearly defined (Fontein-Kuipers et al., 2018). A paradox of tolerance might arise when asking a woman to consider to be tolerant for the health of the child but, in turn, having to be tolerant when a woman makes a decision where the child is subordinate in the maternal deliberation process. Morally intolerable are issues of injustice, unnecessary interventions and oppression. Politically intolerable is anything that lacks consent (Fontein-Kuipers et al., 2019). Tolerance in woman-centred care also

implies that a medical perspective exists next to the biopsychosocial perspective (Fontein-Kuipers et al., 2018; Cronie et al., 2019).

2.14. Purity

The guiding principle in woman-centred care is the physiology of pregnancy and birth (Fontein-Kuipers et al., 2018). Purity refers to an untouched birth, connecting with the physiological and undisturbed forces of the woman's body and with the natural course of birth. To be genuinely in awe, every single time the midwife is present when a woman gives herself and when a child is born (Lyckestam Thelin et al., 2014).

2.15. Gentleness

Gentleness is showing receptiveness to the woman's vulnerability in the modest sense and the kindest of manners

(Comte-Sponville, 2002). Gentleness represents the humanistic perspective of woman-centred care showing in constitutes such as empathy and in being a nurturing and genuine practitioner (Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2018a; Fontein-Kuipers et al., 2019). A gentle touch or a kind word are being recognised to aid to the woman's positive experience of childbirth. Gentleness is apparent when a woman can show her vulnerability, which is being cherished by the midwife, omitting paternalism and control (Lyckestam Thelin et al., 2014; Fontein-Kuipers & Mestdagh, 2021).

2.16. Good faith

Good faith is acknowledging and trusting the woman's embodied knowledge as a trustworthy source of knowledge (Philips, 2009; Fontein-Kuipers et al., 2018; Fontein-Kuipers & Mestdagh, 2021). Good faith is also illustrated when affirming the normality of pregnancy and birth and the fitness and competence of women's bodies for childbearing, as these views are closely linked to woman-centred care (Lyckestam Thelin et al., 2014; Hunter et al., 2017; Brady et al., 2019).

2.17. Humour

In woman-centred care or in midwifery humour is scarcely mentioned although in person-centred care humour has been recognised to be of importance when putting things in perspective and to challenge seriousness during care processes and care relationships - but above all as a vehicle to connect to people (Scholl, 2007). The fact that there is no mentioning of humour in woman-centred care might be related to midwives' perspectives about the always present sense of accountability and responsibility and the professional complexity and dilemmas in an era of risk management and heavy workloads (WHO, 2016; Fontein-Kuipers et al., 2018b). Humour is a manifestation of interpersonal connection and sensitivity and can help women in feeling seen and heard (Scholl, 2007).

2.18. Love

Research about the perceptions and observations among midwives and women, show that woman-centred care is not for every midwife. Midwives either 'love it or hate it' (Philips, 2009; Fontein-Kuipers et al., 2016; Fontein-Kuipers et al., 2019; Fontein-Kuipers et al., 2019a; Petit-Steeghs et al., 2019; Taylor et al., 2019; Hollins Martin et al., 2020; Fontein-Kuipers et al., 2021; Newton et al., 2021). Loving woman-centred care is a combination of desire, joy, fulfilment and satisfaction, connected with existentialism and purpose in and value of life, but constraint from duty (Comte-Sponville, 2002). In other words, the midwife is allowed to be egoistical in enjoying woman-centred care. The virtue of love is represented by experiencing humanity, human capacity and by a flourishing relationship between human beings - which are at the heart of woman-centred care (Lyckestam Thelin et al., 2014; Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019). The love for the relationship with the woman even keeps midwives in the job in difficult times (Sheehy et al., 2021). Love in woman-centred care is also present when stepping back in the available space of the woman-midwife relationship whenever this benefits the woman (Maputle & Hiss, 2013; Fontein-Kuipers et al., 2018). Stepping back allows the woman to take her space in the relationship through utilising her experiential knowledge, her choices, control, self-determination and by actively participating in her own care process. Stepping back provides room for the partner, baby, family and society – acknowledging the woman in her existence (Ahlund et al., 2018; Brady et al., 2019; Fontein-Kuipers et al., 2019a; Fontein-Kuipers et al., 2021;

Fontein-Kuipers & Mestdagh, 2021). Love in woman-centred care also implies stepping back from care that is midwife-led or midwife-focused and stepping back from the needs of the midwifery profession, institution or routines (Parsons & Griffiths, 2007; Leap, 2009; Berg et al., 2012; Edmondson & Walker, 2014; Brady et al., 2019; Fontein-Kuipers et al., 2019; Petit-Steeghs et al., 2019; Cole, 2020; Rigg & Dahlen, 2021).

3. A sketch of pragmatic midwifery socialisation and transformation

This synthesis of virtues provides practical steps in the midwife's thinking process – be(com)ing a *wise woman* and *being with woman*. Translating the virtues into virtue acts allowed to determine what is salient in enabling practical utility of woman-cented care. I am often being asked whether woman-centred care can be taught or learned, or whether a midwife just 'has it' and if it is realistic to expect that all midwives practice in a (similar) woman-centred way. Comte-Sponville (2002) describes the morality maxim. For woman-centred care this means that when the (student) midwife 'does not have it' (i.e. 'does not *love* it'), is unfamiliar with the concept of woman-centred care or, is not convinced this is the aspired way for practice (for whatever reason), the (student) midwife can then *act as though you love it* (Comte-Sponville, 2002). The virtues acts can serve as a guide of stepping-stones to *act as though you love it* and start the journey from transforming woman-centred care from an act into a state. The virtue acts provide the midwife with a plan for creating 'habits of the heart' (Näsman & Nyholm, 2020).

Functioning as a woman-centred care (student) midwife begins within the social context of woman-centred care midwifery and requires pragmatism, through seeking and creating experiences that shape the utility of woman-centred care, envisaging the truth of woman-centred care and discarding its errors (Deering et al., 2020). Various identities of woman-centred care midwives are being recognised in the woman-centred care midwifery community of practice and these identities can be used as a standard in a process of socialisation (Parsons & Griffiths, 2007; Fontein-Kuipers et al., 2019; Cingel & Brouwer, 2020). The pragmatic process of woman-centred care professional socialisation takes place when the (student) midwife acquires specific knowledge, attitudes, beliefs, norms, values and skills that are required to function in a woman-centred way and through overt and covert activities that attempt to modify affect, behaviour, cognitions or relationships (Moore, 2005; Carolan, 2013; Cingel & Brouwer, 2020). The order of the virtues as presented by Comte-Sponville (2002) might not be coincidental as they seem to coincide with the stages of professional socialisation and with the transformative learning theory (Prochaska et al., 1994; Mezirow & Associates, 2000). Because woman-centred care is hitherto not a legitimate accepted midwifery professional conduct and moral, nor is it regarded as ultimate midwifery culture specific care provision, professional socialisation of woman-centred care therefore seems to require transformative learning or growth and self-emancipation of an epistemological woman-centred care perspective in the midwifery profession (Moore, 2005). The two virtues *politeness* and *fidelity,* represent the informal constructs precontemplation and contemplation, forming the anticipatory stage of the professional socialisation process - 'getting ready' (Weidman et al., 2001; Vries et al, 2003; Fontein-Kuipers et al., 2018). The virtues *politeness* and *fidelity* serve as requisites for woman-centred care, embodying cognitive decisional balance, making meaning and creating a frame of reference (Weidman et al., 2001; Moore, 2005; Fontein-Kuipers et al., 2018). On practice level, midwives need to anticipate which actions should be considered in organising practice in such a way that it allows to build a relationship with the woman (Philips, 2009; Fontein, 2010; Fontein-Kuipers et al., 2018; Brady et al., 2019; Fontein-Kuipers et al., 2019). For midwifery students, role models, effective theoretically and practically learning experiences and strategies must be available (Fontein-Kuipers & Romeijn, 2018; Fontein-Kuipers et al., 2018a; Gamble et al., 2020; Hainsworth et al., 2021). For novice woman-centred care practitioners precontemplation and contemplation are the first steps to accomplish becoming a woman-centred care midwife for further progress or growth. The virtue *courage* is the step in professional socialisation where the midwife comes into action where informal becomes formal, where covert actions become overt, by voicing and manifesting orientation and expectations that guide actions and strengthen

autonomy and authenticity (Weidman et al., 2001; Moore, 2005; Sherman, 2009; Jefford et al., 2021). It takes *courage* to overtly voice the woman-centred care vision and to stand up for one's woman-centred care beliefs and to discuss woman-centred care values and boundaries with women and (inter/multidisciplinary) colleagues or an organisation level (Helberget et al., 2016; Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019). *Generosity* and *justice* are the ability factors for *courage* (Vries et al., 2003), to unite midwives and women, and midwives and midwives (Fontein-Kuipers et al., 2018; Bradfield, et al., 2019). *Prudence* serves as a capacity building factor, supporting the process of onboarding (Vries et al., 2003; Karambelkar & Bhattacharya, 2017). *Prudence* supports the fundamental act of constantly transforming and revising woman-centred care meaning into a superior perspective (Moore, 2005; Karambelkar & Bhattacharya, 2017). The socialisation process requires woman-centred care role models, ambassadors, leaders, champions, innovators and (early) adopters among practitioners, educators, academics, and policymakers or among those situated in midwifery organisations with a governing function – to be of merit for professional socialisation and transformation to enable the ethics of responsibility and applied morality of woman-centred care in a more epochal rather than an accumulative way (Moore, 2005; Lake, 2014; Gottlieb & Gottlieb, 2017). *Prudence* is recognised in midwifery education through offering the student the continuity of the same woman-centred care preceptor throughout the education program (Gamble et al., 2020; Hainsworth et al., 2021). *Temperance* is a station for further personal evolution of woman-centred care and a paradigm shift in the midwifery care meaning perspective and actions, a purposeful move to being fully committed to woman-centred care through *compassion, mercy, gratitude, humility, simplicity* and *tolerance*. It has been recognised that acting according to these woman-centred virtue can be an extremely vulnerable and/or overwhelming point in professional socialisation and transformation. The virtues *compassion, mercy, gratitude, humility, simplicity, tolerance* often provoke criticism and dilemma's and might even lead to hostility of peers or colleagues as at this point of professional socialisation (Weidman et al., 2001; Moore, 2005; Karambelkar & Bhattacharya, 2017). (Student) midwives at this point most definitely need support, mentoring and coaching (Burau & Overgaard, 2015; Fontein-Kuipers et al., 2018b; Fontein-Kuipers et al., 2019). *Purity, gentleness, good faith, humour* and *love* are virtues that reflect advanced transformative learning through which woman-centred care is maintained, reinforced and sustained (Vries et al., 2003; Moore, 2005; Karambelkar & Bhattacharya, 2017).

Professional socialisation is marked by points of backsliding and regression. *Courage* is recognised as marking the movement from anticipation to action and *purity* marks the evolution between action and maintenance. *Temperance* can serve as a benchmark for professional socialisation and transformation of woman-centred care, either being experienced or perceived as lacking. This suggests that the professional socialisation and transformation of woman-centred care in midwifery care and education are cyclic or iterative, with recognition and acceptance of regression or lapse. The moment before *courage* can be marked as a point of regression or lapse. *Generosity, compassion, mercy, gratitude, humility, simplicity, tolerance, purity* and *humour* form the action stage where relapse is quite realistic before maintenance of being and doing woman-centred (care) occurs (Moore, 2005; Shahr et al., 2019). *Prudence* might however enable and reinforce the woman-centred care virtue acts (Vries et al., 2003; Karambelkar & Bhattacharya, 2017; Shahr et al., 2019). The woman-centred care interaction level virtue acts *generosity, compassion, mercy, gratitude, humility, simplicity, tolerance, purity, humour* and *love* most definitely directly benefit women (Fontein, 2010; Baas et al., 2017; Fontein-Kuipers et al., 2019a, Petit-Steeghs et al., 2019; Fontein-Kuipers et al., 2021; Fontein-Kuipers & Mestdagh, 2021).

4. Final remarks

Coming back to the question whether woman-centred care can be learned or taught – I think that the answer is yes. Yes, woman-centred care can be explained, shown, developed and mastered by the (student) midwife, when the (student) midwife is facilitated, guided, mentored and supported in following an individual journey (Dickson et al., 2020). Some virtues or virtue acts might be more difficult

to adopt or integrate in embodied midwifery practice than others (Comte-Sponville, 2002). For a successful journey, the (student) midwife needs a nurturing community of practice, a suitable context in education and organisation of practice for the virtues to grow into habits, attitude, and knowledge (Näsman & Nyholm, 2020). In other words, the woman-centred care journey should not be an individual and lonely journey but needs a support base and a footprint that include practitioners, educators, academics and policymakers who formally and overtly promote and take ownership of all woman-centred care virtues and virtue acts (O'Malley-Keighran & Lohan, 2016; Fontein-Kuipers et al., 2019). Thus, when you *love* woman-centred care, *act it* and be a guide and role model or standard (Lake, 2014). But as a midwife, do you have to master *all* virtues to being and doing woman-centred? Ideally yes, but a realistically more nuanced answer is in order. As practice-orientated research has shown that the beliefs, actions and aims of woman-centred care practitioners vary, I think that becoming, being and doing woman-centred (care) is always influenced by personal attributes, values and behaviour as wells as work setting (Fontein, 2010; Fontein-Kuipers et al., 2016; Fontein-Kuipers et al., 2019; Petit-Steeghs et al., 2019; Fontein-Kuipers et al., 2019a; Fontein-Kuipers et al., 2021). It might be difficult to act according to *tolerance, good faith* and *simplicity* in a medical maternity care setting, but as a midwife you can still act according to *humility*. In woman-centred care, the midwife is recognised as a person with own values - providing room for individualisation of woman-centred care management and for midwives' individual differences (Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019). The virtues, present in every human being, can serve as an internal quality implication action and all virtues and virtue acts can be adopted, as a whole or in a fragmented way, as some virtues might be experienced to be more or less commendable, urgent or necessary (Compte-Sponville, 2002; Näsman & Nyholm, 2020). However, I do believe that to benefit women, the formal virtues and their overt virtue acts are essential, for which *courage* is definitely required to voice the more covert and anticipatory virtues. *Temperance* is vital for midwives to remain motivated and committed to being and doing woman-centred care, and I would wish every woman and midwife the midwife to act the virtue *love*. Additionally, to make woman-centred care a legitimate professional conduct and moral and midwifery culture specific, embedding woman-centred care virtue acts in standards of practice and in overall governance are important next steps (O'Malley-Keighran & Lohan, 2016; Crepinsek et al., 2021; Rigg & Dahlen, 2021). Finally, it is of interest to find out what women think of the woman-centred care virtues and the accompanying virtue acts and whether the virtue(act)s address their needs in maternity services. Future research might provide insight in how women experience woman-centred care virtue acts impact on birth and physical and emotional health, wellbeing and care and birth experiences – all equally important outcomes of woman-centred care (Fontein-Kuipers et al., 2018).

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