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From Grief to Grace: An Ethics of Love for Institutions Responding to Perinatal Loss

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Abstract: Perinatal loss—the death of a baby during pregnancy, labor, or shortly after birth—is a singular grief marked by invisibility, fragmentation, and isolation. Though pastoral and moral theologians have long reflected on suffering and its redemptive possibilities, they have paid insufficient attention to the structural conditions in healthcare settings that shape parental bereavement. This paper argues that the movement from grief to grace is not a solitary act of private resilience but a communal and institutional responsibility—one that hospitals must fulfill through practices of love. Healthcare teams and institutions have a moral duty to love grieving families in ways that respect their dignity—including the dignity of the deceased baby—and support their flourishing amid profound loss. Drawing on a personal narrative, the first section shows how bereaved parents often encounter clinical environments that fail to honor their agency and relational needs, thereby compounding their suffering. The second section offers a constructive response through a framework entitled Ethics of Love for Institutions—a framework grounding institutional reform in intentional presence, sensible care, and communal responsibility. Grief becomes grace when institutions—animated by love—uphold both love of self and love of neighbor in the architecture of care.

> "I can do things you cannot, you can do things I cannot; together we can do great things."
> —Mother Teresa

PERINATAL LOSS—THE UNEXPECTED DEATH OF A BABY through miscarriage, stillbirth, or neonatal death—is a heartbreak that resists easy articulation. It touches the mystery of life and death at their most fragile and, in some ways, most alike thresholds. This grief is marked not only by sorrow but also by inner fragmentation and relational isolation—in a word: loneliness. Parents who endure such losses often navigate a complex terrain of invisible mourning, medical disenfranchisement, and relational disconnection.

Christian theology has long reflected on suffering and its transformation through grace into deeper communion with God, neighbor, and self. In Christian moral theology, grace is never a possession but always a gift mediated through relationship, a truth that resonates with contemporary ethics of care emphasizing relational interdependence. Yet, both pastoral and moral theologies have given insufficient attention to the concrete, structural conditions in which such loss unfolds, particularly within healthcare institutions.[1] If, as the Christian tradition affirms, love is the measure of all moral action, then the care of bereaved mothers and fathers must be evaluated not only by clinical competence but also by the degree to which it embodies love in its most steadfast, tender, and just form.

This article contends that the movement from grief to grace is not a solitary achievement of private resilience but a communal and institutional responsibility—one that healthcare settings must actively and lovingly shoulder. Hospitals, clinics, birth centers, and those who inhabit them—physicians, nurses, midwives, social workers, counsellors, chaplains, assistants—are called to a form of accompaniment that honors both the dignity of grieving parents and the dignity of the child who died.[2] This moral duty to love flows not merely from professional ethics but from the conviction that every human being is to be received

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[1] Karen O'Donnell, "Reproductive Loss: Toward a Theology of Bodies," *Theology & Sexuality* 25, no. 1–2 (2019): 146–159; Karen O'Donnell, *The Dark Womb: Re-Conceiving Theology Through Reproductive Loss* (SCM Press, 2022); Jennifer Scuro, *The Pregnancy ≠ Childbearing Project: A Phenomenology of Miscarriage* (Rowman & Littlefield, 2017); Serene L. Jones, "Hope Deferred: Theological Reflections on Reproductive Loss (Infertility, Stillbirth, Miscarriage)," *Modern Theology* 17, no. 2 (2001): 227–45; Ann J. Cahill, Kathryn J. Norlock, and Byron J. Stoyles, eds., "Miscarriage, Reproductive Loss, and Fetal Death," *Journal of Social Philosophy* 46, no. 1 (2015): 1–157; Karen O'Donnell and Allison Fenton, eds., "Theology and Childlessness," *Modern Believing* 60, no. 2 (2019): 103–210; Emily Reimer-Barry, *Reproductive Justice and The Catholic Church: Advancing Pragmatic Solidarity with Pregnant Women* (Rowman & Littlefield, 2024), chapter 5; Amber L. Griffioen, "Toward a Philosophical Theology of Pregnancy Loss," in *Meaning of Mourning: Perspectives on Death, Loss, and Grief*, ed. Mikolaj Slawkowski-Rode (Rowman & Littlefield, 2023), chapter 4.

[2] On the concept of accompaniment (as including the "practices of befriending, living with, listening to") and its relation to solidarity in the medical context, see Jennie Weiss Block, M. Therese Lysaught, and Alexandre A. Martins, eds., "Part 3: Accompaniment," in *A Prophet to the Peoples: Paul Farmer's Witness and Theological Ethics* (Pickwick, 2023), 197–201.

as a gift, and that love must take institutional as well as personal form.[3] To love grieving families is not simply to feel sympathy, but to structure care in ways that uphold their dignity—including the dignity of the deceased baby—and to support their capacity to remain whole amid unimaginable loss. While I draw on my own experience of stillbirth as a point of departure, my purpose is not to center my own grief but to illuminate how even well-intentioned care can falter when shaped more by liability and efficiency than by love. The failures and absences I describe reflect patterns common to many grieving parents—patterns that reveal a broader systemic neglect compounding the loneliness of perinatal loss.

The paper is divided as follows. The first section offers contextual and conceptual grounding. Through narrative and analysis, it shows how hospital staff and protocols, despite good intentions, can deepen grief by failing to honor the moral agency, relational needs, and particularities of each bereaved family. It also clarifies three key terms typically used in the context of grief such as: loneliness (distinguished from solitude); hope (distinguished from mere optimism and illusion); and love (distinguished from mere sentiment or affection). The second section then offers a constructive response: the *Ethics of Love for Institutions*, a normative framework for structural reform grounded in three interdependent pillars—(1) intentional presence (committed yet non-assuming, allowing both accompaniment and solitude); (2) sensible care (universal and personal, allowing flexibility within protocols to meet unique needs); and (3) communal responsibility (shared and differentiated, fostering collaborative decision-making grounded in the complementarity of expertise between families and providers).

Together, these pillars embed love in organizations through intentional presence, sensible care, and communal responsibility. This ethos of institutional love cannot rest on individual goodwill alone but must be woven into the very architecture of care. Grief becomes grace when institutions make space for the full weight of loss and for the bonds of love that endure beyond it—sustaining the bereaved not only in surviving their sorrow, but in finding within it a renewed capacity to give and receive love.

When Organizations Fail to Accompany Grief: The Structural Roots of Perinatal Bereavement

I lost two children *in utero* over the past three years. Because these children died before birth, the losses were, in a way, hidden from the

[3] Thana de Campos-Rudinsky, *The Rule of Love: The Power of Presence for Reforming Health Institutions and Global Health Leadership* (Oxford University Press, forthcoming 2026).

public eye. This hiddenness makes it hard for others to grasp the depth of grief over a tiny, practically invisible human being who was never born, never seen, never heard. This hiddenness compounds the loneliness of mothers who lose someone so profoundly close while also often facing incomprehension, sometimes from those closest to them. A mother's most intimate relationships—family members, close friends, and at times even her husband, the father of that child—may not fully grasp her grief, carried deeply in her womb and her soul.

This lack of understanding is not only painful; it is bewildering. In that bewilderment, my sense of connectedness felt fractured on three levels: a severed bond with my child; an inner disorientation that unsettled my own coherence; and a painful estrangement from family and community. Grief on this scale is never experienced in a vacuum. How others respond—especially within institutions such as hospitals—can either alleviate or intensify it.

Before narrating my own experience to illustrate this claim, I first clarify three key terms often invoked in the context of grief: *loneliness*, *love*, and *hope*. These words are rarely defined in ways that capture their moral and existential depth. My definitions will serve as a basis for the analysis that follows.

DEFINING KEY TERMS IN THE CONTEXT OF PERINATAL GRIEF

Loneliness

Mainstream accounts often define loneliness as the gap between the social life one has and the social life one desires.[4] While capturing part of the phenomenon, this account is too thin to address the loneliness that attends deep grief.[5] I understand loneliness as a specific form of suffering marked by a profound lack of connectedness—not merely the absence of social contact, but the absence of true belonging grounded in mutual care.

Loneliness has both internal and external dimensions: inwardly, it appears as fragmentation—a felt disconnection from oneself and a loss of inner coherence; outwardly, it manifests as isolation from others

[4] For a critical analysis of this dominant framework, see e.g., Zohar Lederman, "The Bioethics of Loneliness," *Bioethics* 35 (2021): 446–455; Ian Marcus Corbin, "What's Behind America's Loneliness Crisis? Loneliness-Production has been a Big Business for a Very Long Time," *Commonweal*, July 24, 2024, commonwealmagazine.org/whats-behind-americas-loneliness-crisis.

[5] Lederman, "The Bioethics of Loneliness," 446–455; Corbin, "What's Behind America's Loneliness Crisis?"

and estrangement from community.[6] In this sense, loneliness is a poverty of communion. Its roots lie not simply in the absence of people, but in the absence of *love*—both love of self and love of neighbor. Without love of self, inner fragmentation deepens; without love of neighbor, social isolation hardens.

Love

Love is a notoriously polysemous word, often conflated with romantic sentimentality or fleeting emotion.[7] I define love as a virtue and a process of practical reason: a deliberate choice that becomes a practice, and over time, an ingrained disposition.[8] Love, as I use it here, is not principally an emotion, but a discipline of attentive reasoning that entails choosing and committing to be fully present to another in reverence for her otherness.

This reading aligns with Aquinas's definition of love as willing the good of the other[9] and von Balthasar's description of mutual love as the place "where the other as other is encountered in a freedom that will never be brought under my control."[10] In the face of suffering, love honors the uniqueness of the other's wounds while recognizing our shared human fragility. Authentic love is neither paternalistic nor complicit in deception. It honors the agency of the other in two ways: first, by refusing to presume what is best without listening; and second, by tempering honesty with discretion, shaping truth in ways attuned to her wounds.

Philosophers such as Simone Weil,[11] Iris Murdoch,[12] and Emmanuel Lévinas[13] describe love as a moral vision—an unselfing

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[6] Eleonore Stump, *Wandering in Darkness: Narrative and the Problem of Suffering* (Oxford University Press, 2010), chapter 7. See also, Lederman, "The Bioethics of Loneliness," 446–455.

[7] Matthew T. Lee, "Love as a Foundational Principle for Humanistic Management," in Michael Pirson, *Love and Organization: Lessons of Love for Human Dignity, Leadership, and Motivation* (Routledge, 2022), 10; Tyler Tate Joseph Clair, "Love Your Patient as Yourself—On Reviving the Broken Heart of American Medical Ethics," *Hastings Center Report* 2, no. 53 (2023): 12–25.

[8] De Campos-Rudinsky, *The Rule of Love*, introduction.

[9] Thomas Aquinas, ST II-II, q. 26, a. 4.

[10] Hans Urs von Balthasar, *Love Alone Is Credible* (Ignatius, 2004), 53.

[11] Simone Weil, "Reflections on the Right Use of School Studies with a View to the Love of God" (1942), in *Waiting for God* (HarperPerennial, 2009). See also, Alexandre A Martins, "Simone Weil's Radical Ontology of Rootedness: Natural and Supernatural Justices," in *Praxis: An Interdisciplinary Journal of Faith and Justice* 2, no. 1 (2019): 23–35.

[12] On the centrality of attentiveness for the definition of love, see Iris Murdoch on the 'just and loving gaze' in *The Sovereignty of Good* (Routledge & Kegan Paul, 1970), 34.

[13] Emmanuel Lévínas, *Totality and Infinity: An Essay on Exteriority*, trans. Alphonso Lingis (Duquesne University Press, 1969).

gaze that perceives the other without illusion or ego and is responsive to her. I understand this vision as both contemplative and active. Love is receptive: it resists control and self-absorption so that others (and oneself) may be perceived in their full reality. But love is also active: it shapes choices and actions in the face of vulnerability—both theirs and mine.

In this sense, love is a relational virtue—a morally clarifying posture that enables genuine accompaniment of another with attention to their singular needs and our shared human fragility. Love of neighbor rests on love of self, and both ultimately rest on love of God: we love because He loved us first (1 John 4:19).

Hope

In suffering, hope is often misconstrued—reduced either to a comforting illusion or to cognitive-behavioral optimism reliant on willpower.[14] Both are distortions. Genuine hope is neither fantasy nor forced positivity; it is a virtue integrating reason and emotion. It may first arise as an affective response to a possible future good, but it must then be chosen, practiced, and sustained over time.[15]

Yet moments of acute vulnerability often diminish our individual capacity to hope. This is why hope, like love, cannot be sustained in isolation: it depends on community.[16] Hope is inherently relational, arising within and nourished by bonds of trust and care. I call this reconstruction *grounded hope*.[17] It is sustained not by illusion or willpower, but through truthful communication—where honesty is tempered by discretion—and by the steadfast presence of others who

[14] C.R. Snyder, "Hope Theory. Rainbows in the Mind," *Psychological Inquiry* 13, no. 4 (2002): 249–75. Similarly, Corn et al. define hope as a "goal-orientated cognitive construct with affective and behavioural implications." B.R. Corn, D. B. Feldman, and I. Wexler, "The Science of Hope," *The Lancet Oncology* 21, no. 9 (2020): e452–9.

[15] Krista Tippett, *Becoming Wise: An Inquiry into the Mystery and Art of Living* (Penguin, 2016).

[16] Hope, in Aquinas' thought, is oriented toward union, but that union is not achieved exclusively through sheer will. Instead, it is received through relationship and sustained through shared labor. As he writes in his commentary on the *Sentences*, "A person who has hope, hopes to attain God, and hopes to obtain through Him all necessities, however difficult, and to repel through Him all harms" (III, d. 26, q. 2, a. 2, ad 2). Even in its divine orientation, hope is not solitary striving—it is a shared journey, and therefore, a form of companionship. Hope is therefore inherently relational. It can only be experienced in communion and community with others. See also, Lydia S Dugdale, "The Virtue of Hope in the Face of Death," *Virtues and Vocations—Reimagining the Character of Professional Education* (Summer 2023): socialconcerns.nd.edu/virtues/magazine/the-virtue-of-hope-in-the-face-of-death/.

[17] Thana C. de Campos-Rudinsky, "Truth, Hope, and Love: Rethinking the Ethics of Communication in Cancer Care," unpublished manuscript.

remain lovingly attentive in the face of suffering.[18] Grounded hope is not about controlling outcomes, but about sustaining meaning and belonging when those outcomes lie beyond our control.

Having clarified these terms conceptually, I now turn to the story that pressed their meaning upon me in ways theory alone cannot capture.

MY STORY

In what follows, I turn from definitions to lived experience. My encounters with perinatal loss illuminate not only the depth of loneliness such events can bring but also the ways institutional practices—despite good intentions—can either corrode or nurture grounded hope. At stake is the failure or fulfillment of love as presence: a commitment to accompaniment attentive to another's singular vulnerability.

I lost Iain, my first son, around the twenty-week mark of pregnancy. In some jurisdictions, a baby's death after twenty weeks is called a stillbirth; in others, miscarriage until week 28. Whatever the term, the reality is the same: my son died in April 2021. My husband and I learned about his death during a routine ultrasound.

"Your baby doesn't have a heartbeat. I am sorry," my doctor tells me.

Those words. When you hear them, your own heart stops for a moment.[19] Though spoken gently, they shattered my soul. It grew as dark and cold inside me as that examination room itself. There was no time, though, to process the enormity of what had happened. The next thing I know is that on the following day I was heading to the hospital to deliver Iain.

Iain was stillborn in April 2021 at 4:11a.m. in Santiago, Chile, after several hours of an induced labor. The morning was cold; the fluorescent light filled the room with a sterile brightness that stung my eyes. When I finally held him, I was struck by how his lifeless body—in all its glory and vulnerability— was so perfectly formed, so still. I remember his eyebrows, how much they resembled his father's. I recall the strange weightlessness of him—both heavy and not heavy at all—resting on my hand for a moment that felt outside of time.

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[18] Ramón Luzárraga offers a theology of accompaniment with a Catholic understanding of suffering and with a rebuttal to prosperity theology based on positive thinking. See Ramón Luzárraga, "Accompaniment with the Sick: An Authentic Christian Vocation That Rejects the Fallacy of Prosperity Theology," *Journal of Moral Theology* 8, no. 1 (2019): 76–88.

[19] On a similar experience, see also Stephanie Duncan Smith, *Even After Every Thing—The Spiritual Practice of Knowing the Risks and Loving Anyway* (Penguin, 2024).

At that time, many might remember, we were still living in a world with many restrictions due to the COVID-19 pandemic. Hospitals—worldwide, but particularly in Chile—enforced strict "no-visitor" and "no-accompaniment" policies meant to contain the spread of the virus. These hospital policies prohibited family members and friends from being with their loved ones in the hospital. Many people died alone[20] and many people gave birth alone[21] because of these policies.

This was my first labor, so there was a lot of fear involved. One often feels fearful when one does not know what is happening. Because I was only five months along, I had not yet begun to prepare for birth and knew very little about labor. So I went to the hospital knowing pretty much nothing about what was going to happen. Perhaps I was naively expecting that upon admission, a dedicated healthcare team of professionals would sit down with my husband and me to explain what was about to happen and how things were likely to unfold.

I had no idea that a doctor I had never met before was going to make *every* decision for me, and that the nurses and professionals under her lead would follow her directions, without any room for prior conversation with us. I had no idea this was the norm in that particular hospital, which had a more hands-on (dare I say "paternalistic") organizational culture, where the doctor was presumed to know best and so made all the decisions with which others—including the patient—were expected simply to comply, no questions asked.

Nor did I realize that COVID-era hospital protocols were so rigid that they allowed no exceptions—not even exceptions that were reasonable and very easy to accommodate (such as giving my husband and me time and privacy with our baby after delivery, or permitting a priest to visit and perform the *Ars Moriendi* rituals with us).[22]

Do not get me wrong. Hospital protocols serve an important purpose.[23] They standardize practices that promote safety and

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[20] Zohar Lederman, "Dying a Lonely Death: A Conceptual and Normative Analysis," *Bioethics* 38, no. 4 (2024): 282–291.

[21] S. Oddo-Sommerfeld, K. Schermelleh-Engel, M. Konopka, V.L. La Rosa, F. Louwen, and S. Sommerlad, "Giving Birth Alone Due to COVID-19-Related Hospital Restrictions Compared to Accompanied Birth: Psychological Distress in Women with Caesarean Section or Vaginal Birth—A Cross-Sectional Study," *Journal of Perinatal Medicine* 50, no. 5 (2022): 539–548.

[22] Lydia Dugdale, *The Lost Art of Dying Well—Reviving Forgotten Wisdom* (Harper One, 2020); M. Therese Lysaught, "Ritual and Practice," in *Dying in the Twenty-First Century: Toward a New Ethical Framework for the Art of Dying Well*, ed. Lydia Dugdale (MIT Press, 2015), 67–86. Mariele Courtois, "Wherever He Goes: An *Ars Moriendi* for Perinatal Hospice," *Christian Bioethics*, 2025, doi.org/10.1093/cb/cbaf008.

[23] S.H. Woolf, R. Grol, A. Hutchinson, M. Eccles, J. Grimshaw, "Clinical Guidelines: Potential Benefits, Limitations, and Harms of Clinical Guidelines," *British Medical Journal* 318, no. 7182 (1999): 527–530.

efficiency—essential in a pandemic, when resources are strained. But when rules are excessively rigid, they carry unintended harm. They can exacerbate the loneliness of those already enduring deep losses.

What my story underscores is that while the loneliness of bereaved parents does not originate in hospital policies—after all, the death of a child is isolating in itself—institutions can intensify that loneliness. They can, often unintentionally, corrode grounded hope. This is not merely unfortunate; it is an ethical failure that institutions have a duty to remedy. This duty is required not only by justice but also by love. Just institutions ought also be loving institutions.

My experience is only one example, yet it points to a broader truth: institutions are not neutral backdrops to grief. Their structures, policies, and cultures shape how loss is lived—either compounding loneliness or making space for communion. Standardized procedures, designed primarily for efficiency and safety, often leave little room for the particularities of each patient's grief. When protocols eclipse conversation, they can silence the moral agency of the bereaved. When rigid rules make no space for privacy, ritual, or integral care, they neglect the relational needs of families. And when every patient is treated as interchangeable, the particularities of each family's grief are erased.

The heart of my own experience revealed this clearly: the most fundamental way to counter loneliness is not through efficiency or technical competence, but through love—understood as attentive accompaniment, lived through dialogue and shared decision-making.[24] When institutions fail to embody this, they risk not only intensifying grief but corroding the very hope they are called to protect.

This insight leads directly to the framework I call "Ethics of Love for Institutions," based on my forthcoming book, *The Rule of Love: The Power of Presence for Reforming Health Institutions and Global Health Leadership*.[25] Just as love at the interpersonal level is a committed, discerning presence to another's singular vulnerability, so too must institutions embody—or risk failing to embody—this virtue in their own policies and practices. In the next section, I identify three pillars of this ethic—intentional presence, sensible care, and communal responsibility—and explore how they can guide organizations in accompanying grief with truth, hope, and love, even amid structural constraints.

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[24] On the tension between efficiency and accompaniment, see Brian Volck, "Wasting Time with the World's Poor: Theological and Scriptural Foundations for Paul Farmer's Praxis of Accompaniment," in Block, Lysaught, and Martins, eds., *A Prophet to the Peoples*, 219–242.

[25] See note 3.

ETHICS OF LOVE FOR INSTITUTIONS: RESPONDING TO PERINATAL LOSS AND REIMAGINING MUTUAL CARE

The stories of bereaved parents are not simply individual accounts of private grief. They are diagnostic tools, revealing the fault lines of institutional structures that too often fail the very people they exist to serve. In my own case, there is a list of practices that would have been helpful for me to feel loved, cared for, and accompanied throughout my perinatal loss. This is not an idiosyncratic list. It reflects recurring themes that surfaced both in conversations with other bereaved parents and in interviews and focus groups I conducted with Chilean hospital administrators, obstetricians, midwives, doulas, and patients. Out of those shared reflections emerged three interdependent pillars of the framework of Ethics of Love for Institutions.

The pillars are not abstract ideals. They describe what love looks like when it is woven into organizational life:

1. intentional presence: presence that is both committed and non-assuming, allowing space for both solitude and accompaniment;

2. sensible care: care that is both universal and personal, allowing reasonable flexibility within protocols to meet each family's unique needs; and

3. communal responsibility: responsibility that is both shared and differentiated, fostering collaborative decision-making grounded in the complementarity of expertise between families and providers.

Together, these pillars form a framework for institutions to accompany grief with truth, hope, and love, not merely through individual goodwill but through the very architecture of care.

Intentional Presence: Committed and Non-Assuming

To love, as mentioned earlier, is to be present: to make the deliberate choice to accompany another, especially in her most vulnerable moments.[26] Love means being wholeheartedly there for the

[26] The idea of presence as 'being with' the other has been discussed in fields as distinct as theology, philosophy, sociology, nursing, and medicine. In theology, see, e.g., Stump, *Wandering in Darkness*, 108–128. In philosophy, see, e.g., Stephen Darwall, "Love's Second Personal Character: Reciprocal Holding, Beholding, and Upholding," in *Love, Reason, and Morality*, ed. E.E. Kroeker and K. Schauroech (Routledge,

one who suffers, without assuming a paternalistic posture that overpowers her agency.[27] It is a firm commitment to stay and bear witness, resisting the impulse to claim superior knowledge or to control the outcome. Intentional presence is therefore both a moral discipline and a relational posture: gazing attentively, listening with empathy,[28] and speaking truthfully—but only after first receiving the other's reality.[29]

What bereaved parents most need is not efficiency or quick reassurance that silences sadness but a committed yet non-assuming presence that responds only after discerning with attention, empathy, and truth. As a bereaved mother, I would have found it healing to be accompanied by someone who could remain with me without being intrusive. I carried so much fear, so much sorrow. It would have helped if a member of the healthcare team had taken the time to talk and to listen with openness. It would have helped if someone had explained what that labor—the labor of a stillborn—entails: what the process looks like, how it would likely unfold, how induction works, the different possible scenarios, what my baby might look like after three weeks in the womb without life—his size, his color, his fragile appearance. To know more would have helped me to fear less.

Yet presence is not primarily about words. While such a conversation would have prepared me for what was coming, presence is not reducible to talking, explaining, or filling silence with well-meaning noise. Often the most powerful witness of love is simply to remain, silently, when words are a disservice. In such moments, it is presence itself, not speech, that sustains.

2018), 101–102; and Stephen Darwall, "Being With," *The Southern Journal of Philosophy* 49 (2011): 4–24. In sociology, see, e.g., Carlos Cousiño and Eduardo Valenzuela, *Politización y Monetarización en América Latina* (Instituto de Estudios de la Sociedad, 2012). In nursing ethics, see Patricia Benner, *From Novice to Expert* (Addison-Wesley, 1984); D.M. Zyblock, "Nursing Presence in Contemporary Nursing Practice," *Nursing Forum* 45 (2010): 120–124; and P.R. Boeck, "Presence: A Concept Analysis," *SAGE Open* (2014): 1–6. In medicine, see, e.g., A. Verghese, "The Importance of Being," in *Health Affairs* 35, no.10 (2016): 1924–1927; D.M. Zulman, M.C. Haverfield, J.G. Shaw, et al., "Practices to Foster Physician Presence and Connection with Patients in the Clinical Encounter," *Journal of the American Medical Association* 323, no. 1 (2020): 70–81.

[27] De Campos-Rudinsky*, The Rule of Love*, chapter 3.

[28] For an ethics of participation that creates the capacity for accompaniment, see a case study of Helping Babies Breathe Sudan, a national program to train village midwives in basic newborn care by Meghan Clark, "Practicing Local Listening with Village Midwives in Sudan: A Case Study for Theological Ethics," in Block, Lysaught, and Martins, eds., *A Prophet to the Peoples*, 233–268.

[29] Presence lies at the intersection of attention, accompaniment, and bearing witness. For a discussion of each of these ideas, see Bryanna Moore, "Seeing and Having Seen: On Suffering and Intersubjectivity," *Cambridge Quarterly of Healthcare Ethics* (2025): 1–10, doi.org/10.1017/S0963180125000064.

Too often, people reach for platitudes or false hope to ease their own helplessness in the face of suffering. In reality, however, such words are usually spoken to comfort oneself, not the one grieving. "It was better this way, something was probably wrong with him" or "you will have another baby soon" may attempt consolation, but they actually isolate. The first may contain the truth, but delivered without discretion only cuts the wound deeper. The second is pure illusion—no one can guarantee such a future. These are evasions, not relief, and they intensify the loneliness of grief. Silent presence—honest, reverent, steadfast—is a truer way to accompany those who suffer. It is act of truth-telling more faithful than premature attempts at solace.

In the context of perinatal loss, then, presence is both simple and difficult: it means showing up, listening, attending, and staying, even—or especially—when words fail. A nurse or physician who remains without rushing away, who allows parents privacy and time to hold their child and say goodbye, communicates more care than any string of reassurance.[30] For institutions, this kind of presence must be intentional, not incidental. Hospitals should actively create the conditions in which committed yet non-assuming presence can flourish: private spaces for parents to spend time with their child, free from unnecessary interventions, and staff trained to honor silence as much as speech.[31] Such structures support both love of neighbor (recognizing the relational needs of parents and their baby) and love of self (allowing bereaved parents to live their grief without suppression). In this way, intentional presence becomes not just the virtue of an individual caregiver but part of the very architecture of care.

Only a few months after Iain's death, Chile approved the *Ley Dominga* (Law 21.371), requiring hospitals and clinics to develop

[30] One may argue that a condition for having staff members lingering 'without rushing away' would be to establish an adequate staffing ratio for infant loss. The ratio would depend on the patient's acuity and the reality of the specific unit. For this the Association of Women's Health, Obstetric and Neonatal Nurses does not have specific staffing guidelines, although they offer a Perinatal Bereavement Program, available at awhonn.org/perinatal-bereavement-resources/. I thank an anonymous reviewer for making this point clear.

[31] Other suggested institutional policies and procedures might include: prolonged length of labor, a prolonged length of time occupying a labor/induction bed if the patient desires a slower induction—or a shortened required post-partum stay if patient desires early discharge, policies outlining options or procedures for density of labor epidural—if the patient wants to experience less of the labor pain than in a live birth, policies for prolonged time with infant and practical institutional accommodations that allow for that, e.g., infant cooling beds, Cuddle Cot, or Cooling Cradle. I thank an anonymous reviewer for listing these suggestions.

specific protocols for perinatal loss.[32] They include: clear explanation of procedures, dignified care for the deceased baby, and a respectful environment for bereaved parents, including a private space apart from maternity wards, proper farewell services, and the possibility of registering the baby in the civil registry. The law was named after a child, Dominga, whose death exposed the need for institutional support. Comparable movements are emerging globally, such as perinatal bereavement care guidelines in the UK[33] and Canada,[34] suggesting that the institutionalization of presence is not a parochial concern but a matter of international ethical agreement. By requiring space, explanation, and ritual, these norms show how intentional presence can be incorporated into policies and embedded in the architecture of care.

Yet presence, if it is to be more than watchfulness, must also be responsive. Love is not only staying but also acting wisely in relation to the particular needs of the other. This moves us from presence to sensible care.

Sensible Care: Universal and Personal

If presence is the first ingredient of loving institutions, care is the second. Care grounded in love is sensible: it should be both universal and personal. It is universal because it should extend and be accessible to all: we all need love and we all ought to give love. Yet universality does not mean homogeneity.[35] Authentic love meets the singular person before me—with her story, fears, hopes, and needs.

To affirm that every patient should receive love, yet in ways that are deeply personal, requires flexibility. Rigid, one-size-fits-all protocols, though intended to ensure safety, fairness, and efficiency,

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[32] Chile, Lei 21.371—Estabelece Medidas Especiales en Caso de Muerte Gestacional o Perinatal (Ley Dominga), 21 September 2021: bcn.cl/leychile/navegar?idNorma=1165684.

[33] Established in 2017 by the National Health System (NHS) in England in collaboration with the charity Sands and professional bodies, the National Bereavement Care Pathway (NBCP) aims to improve bereavement care and reduce variability in provision for families after perinatal death. See the outlined standards and pathways for bereavement care in nbcpathway.org.uk. In 2023, the UK government issued the *Pregnancy Loss Review* outlining comprehensive, compassionate care for pre-24-week pregnancy loss, including personalized support, memory options, and bereavement training for all staff: gov.uk/government/publications/pregnancy-loss-review/pregnancy-loss-review-summary-report.

[34] In 2020, the Canadian Public Health Agency issued the *Family-Centred Maternity and Newborn Care: National Guidelines.* Chapter 7, "Loss and Grief," discusses the role of health care services and community organizations is critical in supporting families experiencing loss any time during the perinatal care trajectory: publications.gc.ca/site/eng/9.887990/publication.html.

[35] De Campos-Rudinsky, *The Rule of Love*, chapter 4.

often obscure the uniqueness of each family's grief. Sensible care therefore entails reasonable accommodations: the willingness to bend rules when compassion and justice morally require it.

Flexibility, however, does not mean that providers must comply with every patient demand. Hospital policies should make space for individual needs within reason, offering exceptions when necessary, in ways attentive to the well-being of both families and caregivers. Reasonable accommodations are not indulgences; they are marks of justice. Just as good laws make exceptions to serve the common good,[36] so too should hospital protocols yield when humanity requires it.

Consider, for instance, an infant born with life-limiting conditions who will survive only hours. Sensible care would allow the baby to remain with the mother and father, to do skin-to-skin, to be held, to be fed, to be cherished. Many hospital protocols demand that such babies be immediately removed to the neonatal intensive care unit. Yet, love and justice call for reason: that is, to let go of the instinct to intervene and instead to honor the family's need for intimacy, memory, and ritual. Liability fears should not justify separating parents from their dying child. A loving institution recognizes that its purpose is neither blind obedience to protocols nor futile medical intervention but the accompaniment of families through life as well as death.

Small gestures make a great difference: providing parents time alone with their child, welcoming clergy or ritual leaders, or permitting simple celebrations—a baptism, a gathering, a photoshoot. These do not abandon standards; rather, they apply them with wisdom, prudence, and discretion. They look beyond the clinical task to the human reality of loss and ask: *What does care mean for this family, in this moment, with this grief*

Ley Dominga (Law 21.371), passed in Chile in 2021, established universal standards for integral care and emotional support for families experiencing a perinatal loss. It requires specialized, multidisciplinary healthcare, dignified treatment of the deceased infant, and the right for parents to create memories, register their child in the civil registry, access psychological and spiritual support, and take work leave.[37] As a result, many Chilean hospitals now provide bereaved parents with memory boxes as part of their new perinatal loss protocol. *Ley Dominga* is thus a landmark example of sensible care. Through the hospital guidelines it inspired, the law universalizes the right to receive adequate and compassionate support while recognizing the need for personal, humane accompaniment.

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[36] I thank Angela Wu Howard for making this point. See her DPhil thesis, "Religious Exceptions to General Laws: Toward an Evaluative Framework, with Special Reference to the American Constitutional Context" (University of Oxford, 2022).

[37] Chile, Lei 21.371.

Although the United States does not have national legislation or guidelines on perinatal bereavement care,[38] most hospitals have developed their own support practices. A study shows that 96 percent of US hospitals give parents a memory box, 99.3 percent offer hand or footprints, 98.2 percent provide a card or sheet with the baby's weight, about 94 percent offer photographs or a baby blanket, and 80 percent provide a birth or delivery certificate.[39]

Yet, even laws and practices grounded in compassion—such as Chile's *Ley Dominga* or the bereavement support programs in the United States—carry the risk of dehumanization when protocols become automatic and blind to the particularities of grief. Indeed, love is not a one-time task, but a practice of ongoing discernment that requires choosing again and again to be present to the other in her singularity. Not every mother wants a memory box or extended time with her deceased child. As one perinatal psychologist we interviewed explained:

> In general, hospital teams work very much by protocol. So, for example, if there is a patient who has experienced a loss, then we hand out a mourning kit, a memory kit. But often for the mother this doesn't make sense—it's not something she was thinking about, or wanted, or felt like doing. "So why are they giving me this little candle?" This creates a sense of mismatch: the patient's experience is not in tune with what the team is doing. The team reacts—and sometimes even overreacts . . . so that the patients may end up feeling a kind of guilt for not being sad, because the team is reacting in such a sad way.[40]

Such mismatches are not uncommon, especially when the pregnancy was unwanted and the child's death comes as a relief. In such cases, protocols designed for grieving parents should not be mechanically applied. When prescriptions become a check-box exercise, love is lost and care collapses into bureaucracy.

Sensible care requires asking before presuming: *How would you like to honor your baby's life?* And it respects when parents decline memories or rituals. What is essential is not the ritual itself but the recognition of the family's agency. Some will ask for religious ceremonies, photographs, or family gatherings; others will want only

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[38] E.C. de Graaff, S.H. Leisher, H. Blencowe, et al., "Ending Preventable Stillbirths and Improving Bereavement Care: A Scorecard for High- and Upper-Middle Income Countries," *BMC Pregnancy Childbirth* 23, no. 1 (2023): 480, doi.org/10.1186/s12884-023-05765-5.

[39] K.J. Gold, M.E. Boggs, and M.A. Plegue, "Gaps in Stillbirth Bereavement Care: A Cross-Sectional Survey of U.S. Hospitals by Birth Volume," *Maternal and Child Health Journal* 28 (2024): 887–894, doi.org/10.1007/s10995-023-03861-8.

[40] Perinatal Psicologista#2, interviewed on August 12, 2025.

privacy and silence. Dr. Elvira Parravicini, director of the Neonatal Comfort Care Program at Columbia University, recalls one family who wanted nothing more than a birthday cake so their children could celebrate their sister's short life.[41] Because the request was theirs, the modest celebration became an authentic expression of love.

Sensible care, therefore, does not end with the offering of services or memory kits. It calls for an ongoing attentiveness to what matters most to families, and a willingness to build care practices around those priorities. This movement—from protocol to dialogue, from uniformity to shared meaning-making—sets the stage for the next dimension of loving institutions: communal responsibility. To become durable, care must be woven into the fabric of communal life, where each carries the proper part of their role.

Communal Responsibility: Shared yet Differentiated

If presence is the first pillar of the Ethics of Love for Institutions, and care is the second, then responsibility completes the triad of this framework. Communal responsibility names the recognition that love is never the work of one person alone. It affirms that we all have a responsibility to love one another and to love ourselves, and that each of us holds a differentiated yet complementary role in building a community of mutual, multidirectional care.

Grief feels solitary, and it calls for solidarity.[42] Mourning is never only personal; it unfolds within networks of caregivers that include family, friends, neighbors, and faith communities. To accompany the bereaved, then, is not the task of one physician, one nurse, or even one parent, but the work of a whole circle of care in which each bears a portion of the weight. Responsibility is communal not because it is vague, but because it is differentiated: each person contributes according to their role and capacity, and together these contributions weave a fabric of belonging strong enough to hold those undone by loss.

For institutions, communal responsibility means resisting the temptation to reduce families to "cases." Hospitals and clinics must learn to recognize parents not merely as recipients of medical expertise but as co-creators of the care they and their children receive. A

[41] Elvira Parravicini, "Perinatal Hospice Care," presented at Perinatal & Hospice Care International Conference, Dublin, Ireland, January 30, 2016. See also Elvira Parravicini, "Neonatal Palliative Care," *Current Opinion in Pediatrics* 29, no. 2 (2017): 135–140; C. Wool and E. Parravicini, "The Neonatal Comfort Care Program," *Frontiers in Pediatrics* 8 (2020): doi.org/10.3389/fped.2020.588432.

[42] On solidarity as a remedy for loneliness, see Zohar Lederman, "Against Loneliness We Unite: A Solidarity-Based Account of Loneliness," *Bioethics* 38, no. 1 (2024): 24–32.

physician's clinical knowledge is indispensable, but so is a mother's intimate knowledge of her body and her child, and so is a father's experience of grief and endurance. Love, in this sense, requires shared authority—a willingness to honor the complementarity of roles and to make decisions together rather than imposing them from above. Because the dignity of each member is preserved precisely through differentiation and mutuality, authority when shared becomes not diluted but more truthful.

This requires institutions to embody a *relational view of accountability*.[43] When accountability is understood not as an external demand enforced through blame or liability but as a reason-giving relationship, then both ends bear responsibility:[44] parents to articulate their needs and hopes as clearly as they can, and professionals to listen with empathy,[45] respond with truthfulness, and adjust practices in reasonable ways that foster trust. This horizontal structure of co-deliberation corrects the distortions of hierarchical paternalism while avoiding the equally dangerous temptation of unchecked consumerism.[46] It is not a matter of "the doctor knows best" or "the patient decides everything," but of *mutual answerability*—a shared labor of discernment aimed at the good of the family, the child, and the healthcare professionals alike.

Communal responsibility is not merely the coordination of tasks; it is the practice of sustaining meaning together. It recognizes that grieving is also the work of rebuilding intelligibility—the slow, collective reweaving of a life-story torn apart. Institutions, by embodying this relational view of accountability, can become sites not of alienation but of communion: places where families are not abandoned to carry grief alone, but where love is structured as shared responsibility.[47]

The truth is that no single person can carry grief's burden, just as no single hand can hold all of love's labor. In our own mourning, it was not the hospital alone or one friend or one family member who

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[43] C. Stephen Evans, *Living Accountably: Accountability as a Virtue* (Oxford University Press, 2023), chapter 2.

[44] Evans, *Living Accountably*, chapter 2.

[45] On the relationships of empathy and interdependence among the different parties in an exchange, see Lisa Sowle Cahill, *Theological Bioethics: Participation, Justice, Change* (Georgetown University Press, 2005), 38.

[46] Caterina Milo and Thana C. de Campos-Rudinsky, "Consent to Treatment," in *Diverse Voices in Health Law and Ethics*, ed. E.C. Romanis, S. Germain, J. Herring (Bristol University Press, 2024), 177–194.

[47] Other examples of places that may embody this relational view of accountability and where love may be structured as shared responsibility are support groups and gatherings for parents after their loss. See, e.g., northsidepnl.com. I thank an anonymous reviewer for this suggestion.

sustained us. While our circle of care extended once we left the hospital, the hospital itself continued to accompany us. The unexpected presence of Anamaria—a healthcare chaplain and member of the hospital's Spiritual Accompaniment Team—who journeyed with us for several months after our son's death, was key to our healing.[48] Her visits, regular yet never intrusive, gave form to a love that did not abandon us in to our loneliness. As my husband and I struggled to make sense of the loss and, at times, of each other, she was there not with answers or strategies, but with a steadfast willingness to inhabit our very different ways of grieving. She listened to my silence and sorrow; she respected my husband's need to cook and clean his way through pain. What first felt like estrangement in our marriage began to appear, through her presence, as complementarity: I could rest in stillness, knowing that he, in his motion, was also caring for us. Her accompaniment revealed that care does not erase differences in grieving but honors them as different ways of giving and receiving love. In this way, communal responsibility resists the homogenization of grief, allowing diversity itself to become a site of healing. There can be unity in diversity, indeed. Anamaria's presence was not hers alone; it represented a community of care that made it possible for us to endure together what we could not endure alone.

This is what communal responsibility looks like: differentiated but shared, fragile but faithful. It is the recognition that love must become institutional as well as personal, sustained across roles, professions, and communities. Only then can grief be carried in a way that does not collapse into loneliness but opens, however painfully, into belonging. It is then that grief begins to move towards grace.

CONCLUSION: FROM GRIEF TO GRACE

Perinatal loss confronts us with the stark truth that love does not shield us from grief but has the power to transform it. To lose a child is to be undone, to watch meaning itself unravel. What parents most need in such moments is love embodied through presence, care, and responsibility. Yet too often, institutions falter at precisely this point, reducing families to cases or procedures, and in so doing, compounding their loneliness.

The movement from grief to grace cannot be left to private resilience. It is, as this paper argued, a communal and institutional responsibility—one that hospitals and healthcare teams must embrace if they are to serve not merely as providers of treatment, but as

[48] The hospital chaplain did not initiate post-discharge contact without our prior request. Her name is disclosed with her permission.

communities of mutual care. The Ethics of Love for Institutions offers a way forward: to be intentionally present with the bereaved, to care in ways that are sensible to the textures of their suffering, and to bear responsibility in differentiated but shared ways.

In our own journey, it was not individual willpower but the faithful presence of others—professionals, family, friends, and communities—that allowed grief to open, however haltingly, into belonging. Grace, then, is not the erasure of sorrow but its transformation within a community of care. It is what becomes possible when institutions are animated by love, and when love takes form as shared responsibility for one another's dignity and flourishing.

When institutions embody this ethic, they become more than sites of medicine; they become places where grief is neither pathologized nor ignored, but honored. They become places where parents are recognized as whole persons, and where the dignity of the deceased child is equally cherished. In such spaces, families discover that love of self and love of neighbor are not opposed but interdependent—each sustaining the other in the long labor of mourning and care.

What makes this labor durable is hope. Not hope as naïve optimism or denial, but hope as communal meaning-making[49]: the shared work of reweaving intelligibility when life's story has been torn apart. This hope is not an individual possession but a relational achievement—hope grounded in love. This *grounded hope* arises when others are willing to inhabit our grief with us, to honor its silence, to respect its diversity of expression, and to carry with us what we cannot carry alone.[50]

The Ethics of Love for Institutions is, at heart, an invitation: to imagine hospitals not only as places of treatment, but as places of communion; not only as spaces of loss, but as spaces where grief can be carried together. If embraced, this vision can help grieving families discover that even amid the most shattering losses, the movement from grief to grace is possible—not through private strength alone, but through love sustained in common, and hope made flesh in community.

[49] On the centrality of meaning-making in the context of suffering, see also Laura Shannonhouse, Jamie Aten, M. Elizabeth Lewis Hall, Eric Silverman, and Jason McMartin, "Christian Meaning Making through Suffering in Theology and Psychology of Religion," *Journal of Moral Theology* 9, no. 1 (2020): 120–35.

[50] De Campos-Rudinsky, *Truth, Hope, and Love* (unpublished manuscript); and S. Bertaud, M. Suleman, D. Wilkinson, "Hope Pluralism in Antenatal Palliative Care," *Journal of Medical Ethics* 51 (2025): 521–525.

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