Bearing One Another's Burdens: A Latter-day Saint Hermeneutic of Organizational Ethics in Medicine

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In honor of Mary V. Rorty, PhD

Mary V. Rorty, Patricia H. Werhane, and Ann E. Mills argued that modern health care institutions need "organization ethics" because ethical failures in hospitals arise not merely from bad choices or isolated bedside dilemmas, but from conflicting roles, fragmented responsibility, institutional secrecy, and decisions whose consequences spread far beyond the people who make them (Rorty et al., 2004). That secular insight is also useful for religious approaches to medical ethics. A Latter-day Saint hermeneutic of medical ethics, as I use the term here, reads scripture, including the *Book of Mormon* and the *Doctrine and Covenants*, for insight into stewardship, accountability, truth-telling, and the moral uses of institutional power in medicine. Because medicine is shaped by the moral imagination of patients, clinicians, and institutions alike, religious traditions can clarify how communities understand responsibility, obligation, and care.

A good place to begin is Mosiah 18, which describes the covenantal obligations of a community. Alma explains that those who enter into a covenant must be "willing to bear one another's burdens, that they may be light," to "mourn with those that mourn," and to "comfort those that stand in need of comfort" (*The Book of Mormon*, 2013, Mosiah 18:8–9). A common reading treats this passage as a call to private kindness. Yet to "bear" another's burdens also means to take on some share of what weighs another person down. Likewise, to "mourn with" and "comfort" others implies a durable relation of responsibility rather than a passing emotion. In a medical context, this duty expands ethics beyond bedside sentiment. A hospital that helps physicians, nurses, patients, and staff bear burdens together is less likely to leave ethical conflict to isolated individuals. Each year, matriculating medical students recite the Hippocratic Oath, promising to "consider my [teacher's] family as my own brothers" (Hippocrates, 2022, p. 299). This promise echoes the covenant to care for medical colleagues as one might care for family. An LDS reading of Mosiah 18 therefore supports the kind of organizational ethics process Rorty et al. (2004) called for: a structure in which burdens are shared and ethical strain becomes a communal responsibility rather than a private one.

Doctrine and Covenants 121 deepens this institutional reading. This section is often quoted for its warning that "it is the nature and disposition of almost all men, as soon as they get a little authority, as they suppose, they will immediately begin to exercise unrighteous dominion" (*Doctrine and Covenants*, 2013, 121:39). That line is especially relevant to hospitals and health systems, where authority is diffuse and often shielded by bureaucracy. The passage begins from a realistic account of human weakness. Power predictably distorts judgment. For that reason,

organizations cannot rely on the character of leaders alone. They need processes and habits that restrain domination.

When authority operates “by persuasion, by long-suffering, by gentleness and meekness, and by love unfeigned” (*Doctrine and Covenants*, 2013, 121:41), those terms become standards for legitimate authority. “Persuasion” implies reasons that can be offered publicly. “Gentleness and meekness” rule out the use of office for humiliation, concealment, or self-interest. “Love unfeigned” rejects manipulative benevolence or institutional self-protection disguised as care. *Doctrine and Covenants* 121 thus offers a theory of organizational legitimacy. An institution becomes ethically suspect when authority no longer persuades, when it conceals relevant truth, or when it asks subordinates to protect the organization at the expense of the vulnerable. Rorty et al. (2004) identified this problem when they argued that health care institutions need explicit ethical processes rather than mere reliance on tacit professional codes, by which they meant the unwritten habits and assumptions professionals rely on without making them public, testable, or institutionally accountable.

Where Rorty et al. (2004) show why institutions need formal ethical processes, an LDS perspective helps explain why informal virtue so often proves insufficient. Spencer W. Kimball (1979) once stated, “Jesus saw sin as wrong but also was able to see sin as springing from deep and unmet needs on the part of the sinner” (para. 18). Applied to medicine, that insight suggests that an ethical institution must also address the pressures, silences, and neglected obligations that make abuses easier to commit and harder to resist. Abuses of power often grow out of unmet needs, neglected responsibilities, or forms of isolation that an institution has failed to address. The community’s covenantal duty to bear one another’s burdens therefore requires helping relieve the pressures under which wrongdoing takes root.

A third helpful text is *Doctrine and Covenants* 104, with its repeated language of stewardship. In Latter-day Saint thought, stewardship implies entrusted care under judgment. One does not own what one administers absolutely. One answers for it (*Doctrine and Covenants*, 2013, 104:11–13). That idea is powerful in medicine because it reframes professional and administrative roles. Physicians are not merely autonomous experts. Administrators and board members are not only fiduciaries in a corporate sense. All are stewards of goods such as the trust of patients, the labor of clinicians, the integrity of the institution, and the health of the community.

If every role in a hospital is a stewardship, then ethical conflict cannot be reduced to one person’s conscience. The problem becomes structural: How are these stewardships coordinated, checked, and rendered accountable to one another? An LDS hermeneutic therefore converges with Rorty et al.’s (2004) systems approach. No single role in a hospital sees the whole moral picture. The patient sees one truth, the physician another, the administrator another, the board another. The ethical question is whether the institution has practices that let these partial truths meet one another before mistrust hardens into silence, concealment, or neglect.

Rorty et al.'s (2004) account shows why organizations need ethical processes. Hospitals need more than good clinicians and decent intentions. They need structures that make truth-telling possible, authority accountable, and burdens genuinely shared. An LDS reading of scripture contributes one moral vocabulary for that institutional task: stewardship instead of possession, persuasion instead of domination, and burden-bearing instead of isolation. In a plural field such as medicine, ethical reflection grows richer when communities bring their strongest accounts of obligation into public view. This hermeneutic offers one such account and joins a broader conversation about how institutions should distribute power, protect the vulnerable, and teach people to carry responsibility together.

References

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