Abstract. Catholic ethical teaching has increasingly relied on a concept of the common good for making and evaluating social decisions. The authors have argued that the common good is a maximal and ideal concept about which people and communities differ fundamentally. In practice, it does not resolve moral and social disagreements. The concept of the common harm is preferable because it is a minimal standard that can be more clearly identified and agreed for individuals and society, providing a basis for legislative and social action. Bioethics and public health both have strong roots in doing no harm and preventing harm to both individuals and communities in society. The authors argue that the application of the concept of the common harm from these disciplines into wider use in the health professions and public policy would be beneficial.


The concept of the common good has been fundamental to the Roman Catholic Church’s social ethical teaching, shaping its public policy and reaching out to wider society. We can weigh what is good and bad and what is good and bad for us. As a community, we need to consider what is the common good. For example, the Bishops’ Conference of England and Wales stated, “The common good is about how to live well together. It is the whole network of social conditions which enable human individuals and groups to flourish and live a full, genuinely human life. At the heart of the common good, solidarity acknowledges that all are responsible for

Katherine Wasson, PhD, is an assistant professor at the Neiswanger Institute for Bioethics of the Stritch School of Medicine at Loyola University Chicago, where she is also the director of the honors program in bioethics and professionalism. E. David Cook, PhD, was formerly fellow and chaplain of Green College, Oxford, and Holmes Professor of Faith and Learning at Wheaton College in Illinois.
all, not only as individuals, but collectively at every level. The principle of the common good expands our understanding of who we are and opens up new sources of motivation. The fulfilment which the common good seeks to serve is the flourishing of humanity.”¹ The common good sets a maximal standard of flourishing for all human beings and society as a whole. Appealing to the common good means that social ethical decisions should be made not only based on what is good for a given individual, but also for the community and wider society.

Setting a maximal or ideal standard raises critical questions, namely, Who decides the specifics of what is in the common good and what counts as flourishing? Can we reach agreement on what is in the common good and how we calculate it? While there may be fundamental elements needed for human beings to flourish, such as food, shelter, clothing, safety, and health, it may be difficult to agree on what is maximally needed to satisfy the common good. Furthermore, the common good may have limited application in practice when different views of what people regard as good and good for them lead to fundamental disagreement about lifestyles and public policy, such as in the marriage equality debates.

We have argued that the common harm is a more useful alternative to the common good.² The common harm is the other side of the coin from the common good. The common harm serves as a minimum standard of what causes recognized harm to individuals and communities and should be avoided. It focuses on a threshold below which individuals and society should not fall to avoid harm to both. It sets a minimum versus a maximum standard for making decisions and shaping public policy. We argue that bioethics and public health have strong roots in this concept, which supports the rationale for using the common harm for societal decision making, not only in these areas but regarding wider social issues as well.

The Common Harm in Bioethics

Bioethical issues reveal the lack of consensus and how hard it is to reach moral agreement. In the Western world, these ethical divisions are also marked by the tension between a deep commitment to autonomy and a genuine concern for social justice. In medical and nursing education and practice, there is a struggle between the different moral perspectives of practitioners themselves and those of patients, families, and the wider public. To minimize these gaps, we need multiple ways forward to facilitate personal and societal decisions and actions. Appealing to the common harm seems a key concept and practice.

Both utilitarianism and Catholic social teaching on the “common good” have tried to facilitate moral discourse with a solid agreed basis. Both have been unsuccessful and are open to a wide variety of critiques focusing on problems with the specific content of both views and the lack of agreement reached within society about

¹ Catholic Bishops’ Conference of England and Wales, Choosing the Common Good (Stoke-on-Trent, UK: Alive Publishing, 2010), 8.
what constitutes the common good or the greatest happiness. We have argued that the idea of common harm may be a more constructive base for social ethical thinking.\(^3\)

The principle of *non nocere*, or nonmaleficence, is fundamental to bioethics, medical practice, and health care more broadly. It is embedded in the Hippocratic Oath taken by physicians over the centuries. First, they pledge to do no harm to their patients. Only after enunciating that principle, do they express a duty to try to do good. Tom Beauchamp and James Childress’s *Principles of Biomedical Ethics* states that “in medical ethics [nonmaleficence] has been closely associated with the maxim *Primum non nocere*: ‘Above all [or first] do no harm.’”\(^4\) Nonmaleficence is fundamental to the doctor–patient relationship and has been expanded to include other health care professionals. Doing no harm takes priority in theory and practice over doing good to patients. If physicians harm their patients, whether intentionally or unintentionally, they may be liable for that harm. Interestingly, there is little attempt to legislate for doing good. Once doctors and other health care professionals fulfill the duty of nonmaleficence, they can then focus on beneficence. There is agreement in these medical and bioethical principles and duties that doing no harm is a priority, or minimum standard, which must be met. Doing good is a maximum standard which is not always possible to meet.

In Bernard Gert, Charles Culver, and K. Danner Clouser’s book *Bioethics: A Systematic Approach*, they offer an account of our common morality.\(^5\) Their focus is more on analyzing impartiality, rationality, and morality and articulating their approach to specific medical ethical conflicts like abortion, death and disease, and mental disorders. The point of morality, according to them, is the lessening of the amount of harm or evil suffered by those protected by morality.\(^6\) Morality is there to limit and, where possible, prevent harm to individuals and society rather than simply to promote good.\(^7\) For these authors, the key insight expressed by the principle of nonmaleficence is also a major orientation of their account of morality. They claim nonmaleficence is the only one of Beauchamp and Childress’s four principles (autonomy, nonmaleficence, beneficence, and justice) that “does not blur the distinction between moral rules and moral ideals.”\(^8\) For them, nonmaleficence is “most reasonably interpreted as merely summarizing some of the moral rules,” which include “‘Don’t kill,’ ‘Don’t cause pain,’ and ‘Don’t disable.’”\(^9\) They suggest that having just the one principle is minimal and transitory at best and prefer to distinguish different kinds of harms, listing in particular: death, pain, disability, loss

---

\(^3\) Ibid.


\(^6\) Ibid., 11.

\(^7\) Ibid., 13–14.

\(^8\) Ibid., 110.

\(^9\) Ibid.
of freedom, and loss of pleasure.\textsuperscript{10} While parsing the nature, content, and priority of harms is important, this merely particularizes the key insight that avoiding harm is a long-standing principle of medicine.\textsuperscript{11}

Regarding nonmaleficence, it is clear that doctors and nurses are in the business of seeking to alleviate or minimize harm and pain and not to cause it. This is true for individual patients in physical, psychological, and even spiritual discomfort where possible. Medical and nursing school curricula include and emphasize a holistic approach to patient care. The aim of these professions is to restore what counts as normal function. Food, drink, and comfort are given to sustain the body and maximize its functioning to be as free from pain as possible. This principle is equally the case in dealing with psychological issues, where the concern is to stabilize and help each patient function as normally as possible for that person and how they interact with society.

Moving from the individual to wider society, there are multiple examples of protecting individuals and communities from harm and common harm. This parallels a shift in the perspective within medical practice and bioethics to a stress on public health ethics and efforts, part of which is a stress on greater personal responsibility to avoid harm from poor diet and lack of exercise. Many public health efforts in history have focused on preventing harm to a community or population (i.e., limiting the common harm to the many). The 1980 Black Report in the United Kingdom identified key areas affecting health and made proposals for enabling the well-being of individuals and society.\textsuperscript{12} The results of the committee’s reflection and review of the evidence was that water, sanitation, housing, and diet were the keys to health. Daily school milk, the provision of school meals, and food supplements such as cod liver oil and Virol malt extract for children were part of society’s obligation. In addition, government was encouraged to limit harm by providing housing and sanitation for its members to ensure their well-being. This policy approach was based on the recognition that removing and limiting the harm inflicted by disease and discomfort was vital for improving the health of individuals and the community.

Efforts to eliminate infectious diseases from water sources through better sanitation were clearly aimed at protecting communities and populations from acquiring and transmitting diseases. This intervention of improving water delivery and quality through legislation and public work schemes, of course, happened long before the Black Report, as the link between disease and water was noted in John Snow’s study based on the Broad Street cholera outbreak in 1854 in the Soho district of London.

More recently, public bans on smoking were slow to be implemented because arguments for individual autonomy were strong, and Western society allows people to undertake risk or to harm themselves to some degree without intervention. The public shift came about when the link between passive smoking and harm to many

\textsuperscript{10} Ibid., 111.

\textsuperscript{11} Ibid.

\textsuperscript{12} Peter Townsend and Nicholas Davidson, eds., \textit{Inequalities in Health: The Black Report} (Harmondsworth, UK: Penguin, 1982).
unintended individuals and groups was established.\textsuperscript{13} Public opinion, tolerance, and policy changed (i.e., no smoking in the workplace and public venues was permitted) when harm to others was soundly established. Public policy was put in place to limit the common harm rather than to promote the common good. Other attempts to limit the common harm have been seen in the bans on trans-fatty acids and large soda sizes in New York City, with varying success.

In the medical realm, outbreaks of measles, mumps, rubella, polio, influenza, and other diseases are examples of the common harm in health care and to the health of the public. These morbidity and mortality rates contribute to the common harm and individual harm. In order to limit the common harm from such diseases, schools require children to be vaccinated to prevent harm both to themselves and others in the population. If a high enough proportion of children are vaccinated against polio, for example, that population will reach “herd immunity,” and nearly all people in that group will be protected from that harm because the disease will die out or at least the rate of transmission will fall significantly. Similar arguments are proposed in the human papillomavirus debate.

Another example within health care is how genetic developments have changed medical practice. One key example is the link between breast cancer and genes. Predictive genetic testing and carrier screening mean that preemptive mastectomy has now become a relatively common response to avoid the harm of breast cancer. A woman found to be carrying the BRCA1/2 mutations may decide to have a mastectomy to prevent the harm caused by developing breast or ovarian cancer in future. Population-based screening for breast or prostate cancer is done with the aim of early detection of disease to limit, prevent, or eliminate the harm from the disease. It can be argued that the primary aim is to prevent individual and common harm, while the secondary aim is to promote the common good through lower disease rates.

Preventive health care notes new threats to health and tries to be proactive in suggesting lifestyle changes to prevent harm. Western societies have seen a dramatic rise in obesity among children and adults. The harmful effects are clearly established. Thus, individuals and public policy and practice have stressed the importance of proper exercise and a healthy diet in avoiding the harm and disease caused by obesity. What we are experiencing in modern society is less emphasis on the responsibility of health care professionals to limit harm and produce health by active intervention and more emphasis on personal responsibility for one’s own health. This, crudely put, is to avoid harm, ill-health, and disease caused by how we live, what we eat, and how much we exercise (or not). As the harms that result from certain diseases and lifestyles have been more clearly established, this increasing emphasis on personal responsibility has become more effective in changing practices among individuals and communities.

\textsuperscript{13} There is debate about the strength or weakness of this association. See Geoffrey Kabat, “The Passive Smoking Issue Is a Rorschach Test for the Ability to Think Scientifically,” \textit{Forbes}, December 21, 2013, http://www.forbes.com/sites/geoffreykabat/2013/12/21/the-passive-smoking-issue-is-a-rorschach-test-for-the-ability-to-think-scientifically/.
Benefits of Appealing to the Common Harm

This focus on avoiding harm shows the need for a clear picture of what harm there is, how it affects us, and what we can do to limit or avoid such harm. We all agree that harm is to be avoided and are motivated and act individually and socially on our desire to avoid it. Avoiding harm—the common harm—is the basis and motivation for much of public health. Public health policies are drafted and enforced where there is a clear sense of harm to the individual and the community. Advances in areas like genetic testing and heart health, and improvements in the quality of life for the aging and disabled, all arise from our desire to avoid harm. While it is not easy to arrive at a positive view of what health and well-being are, we can more easily agree on what harms us and what we wish to avoid. A greater stress on common harm in bioethics and social ethics would provide us with help in the vexing area of allocating health resources. If we can agree on what harm should be avoided or minimized, we can produce relevant policies that will be more persuasive in society generally. Legislation related to vaccination and smoking show how this approach works in practice. Such focus would help with public policies in hospitals, health systems, and health provision. It would provide more solid and effective bases for political and medical decisions. It would help individuals and communities identify and prevent risks to health and well-being.

Stressing the common harm may not enshrine principles of justice and autonomy, but it does drive us to reflect on what it means to be in a community and to be part of a society. Our individual health and well-being are clearly related to others and how we treat them and are treated by them. This means that common harm is something that facilitates joint as well as personal action. The culture wars have reinforced profound differences in what we think is best for us as individuals and as a community. A focus on common harm would allow us to begin to move beyond that disagreement and base our personal and social actions and policies on empirical grounds where actual physical, psychological, and spiritual harm may be established and pave the way for open discussion about how best to limit such harms.

This approach will not become a legalistic process because it must always be open to the test of empirical reality and the scientific establishment of what constitutes actual harm as opposed to our theoretical or individual understandings. Facts will be the main focus of debate rather than opinion and interpretation. An emphasis on common harm will not be reductionistic as long as we have a clear understanding of the complexity of human beings and how we are negatively (or positively) affected by our world and each other. It is more direct to know what harms us now. We fear what harms us and fear harm that may await us if we fail to act or if we continue harmful practices. It is harder to agree on what will harm us in the future unless the facts are indisputable. It is also hard to agree on what to do to avoid such harm. Inevitably, other moral principles, like autonomy, justice, and sheer pragmatism, will be crucial in that debate. But focusing on harm means that at least there will be some agreed basis for these discussions.

The notion of common harm will be beneficial in teaching bioethics to doctors and nurses. It will give patients and their families a clearer understanding
of the effects of their lifestyle and behavior on their own and others’ well-being. It will help us in addressing and navigating the complex social and political areas not only in medicine and public health but also in other deeply divisive issues such as gun control, environmental concerns, and abortion and euthanasia. It may also help us in parsing our understandings of health, human flourishing, happiness, and our hierarchy of moral principles and grounds.