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THOUGHTS

Non-adjectival bioethics

La bioéthique non adjectivale

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Summary It has become customary to think about bioethics as populated by ''adjectival bioethics'' such as utilitarian bioethics, deontological bioethics, Christian bioethics, feminist bioethics, and more. The unfortunate outcome of such a designation is a perception of bioethics as incapable of offering definitive conclusions of practical or social importance, and so as useless for a modern pluralistic society. Accordingly, it is not a viable alternative to traditional ways of dealing with ethical issues associated with medicine or relations between human beings and non-human nature. Moral pluralism of the society is mirrored by the multiplicity of views of bioethicists and plurality of adjectival bioethics. The paper argues for an understanding of bioethics that is better suited to a pluralistic democratic society. On this view, bioethics is a complex of ideas, commitments, and practices, which enables the exchange of opinions of both experts of various specialities and lay citizens about ethical problems associated with medicine and relations between human beings and non-human nature. Such ''non-adjectival bioethics'' relies on a paradigm of intellectual engagement in the form of public debate, which is characteristic of a democratic society. The argument proceeds in two steps. The first step (which focuses on various forms of reflection on ethical issues in medicine but its conclusions apply to all fields of bioethics) starts with two distinctions. One distinction is between the medical-professional perspective and normative-theoretical together with a doctrinal perspective on ethical issues regarding medicine. The other distinction is between bioethics as academic research and education and bioethics as a practice of public debate. On the ground of these distinctions, the non-adjectival view of bioethics is offered. It is a two-layer discourse, which covers both academic research and instruction, and a social practice of public debate that involves professional, normative-theoretical, and doctrinal components. The goal of the debate is to clarify publicly recognised ethical problems and, if possible, offer their publicly shared solutions. Such a non-adjectival bioethics is normative; it functions on various forums and engages academics, the professions, and laypersons. The second part of the paper discusses normative presuppositions of non-adjectival bioethics. It is conceived of in the spirit of deliberative view of public decision-making. Non-adjectival bioethics is animated by two normative sources. One source is democratic values and ideals, such as individual liberty, equality, mutual

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recognition, and respect, which form the broadest normative framework for a public debate of a democratic society on publicly identified ethical issues. The other normative source of non-adjectival bioethics is doctrines, which are endorsed by citizens populating the society. These doctrines are valuable pools of reasons and arguments that can be examined in the bioethical debate. Non-adjectival bioethics is therefore a discourse and discipline, which is defined and bounded by the democratic values and ideals. Unlike adjectival bioethics, which aspire to universally bind conclusions by building their normative claims on metaphysical doctrines or to being a freestanding theory or framework, non-adjectival bioethics looks for clarifications and solutions of ethical problems recognised by pluralistic democratic societies, which are founded on such moral values and ideals as individual liberty, equality, and mutual recognition, and respect.

MOTS CLÉS
Bioéthique ;
Démocratie ;
Éthique médicale ;
Pluralisme moral

Résumé Il est devenu coutumier d'identifier la bioéthique avec la panoplie de « bioéthiques adjectivales » : bioéthique utilitariste, bioéthique déontologique, bioéthique chrétienne, bioéthique féministe, etc. L'un de résultats négatifs de cette tendance est la propagation du scepticisme quant à la capacité de la bioéthique à offrir des solutions définitives, pratiques et socialement utiles, donc du scepticisme quant à sa pertinence dans la société moderne pluraliste. Vue de cette manière, la bioéthique ne semble pas comme une alternative viable aux méthodes traditionnelles pour résoudre les problèmes éthiques qui se présentent dans le contexte médical ou dans celui de relations entre les êtres humains et la nature non humaine. Le pluralisme moral dans la société se traduit par la pluralité de positions bioéthiques et la pluralité de « bioéthiques adjectivales ». Cet article cherche à défendre une conception de bioéthique mieux adaptée aux besoins de nos sociétés pluralistes. La bioéthique qu'il propose fonctionnerait comme une plate-forme ou un cadre d'idées et d'engagements qui favoriserait l'échange d'opinions entre spécialistes et profanes sur les problèmes éthiques dans le domaine de la médicine, ainsi que ceux associés avec les relations entre les êtres humaines et la nature non humaine. Une telle bioéthique non adjectivale se situerait dans le paradigme d'engagement intellectuel en forme de dialogue public caractéristique pour la société démocratique. L'argument que l'on propose avance par deux étapes. La première étape (liée aux manières variées de délibérer sur des problèmes éthiques dans la pratique médicale) commence par deux distinctions. La première est celle entre la perspective médico-professionnelle et la perspective normative-théorique et doctrinale. La seconde est la distinction entre la bioéthique en tant que discipline académique et scolaire, et la bioéthique en tant que pratique de débat public. C'est sur le fondement de ces distinctions que la conception de la bioéthique non adjectivale est exposée. Comme débat, elle fonctionnerait à deux niveaux qui répondent, d'un côté, à son composant académique et scolaire, et de l'autre, à la pratique sociale du dialogue dans lequel les perspectives professionnelles, normative-théoriques et doctrinales ont toutes leurs représentants. Le but de ce débat serait de clarifier les problèmes éthiques largement reconnus dans la société et, là où c'est possible, de trouver des solutions universellement acceptables. Une telle bioéthique serait normative, non adjectivale, pluricentriste et ouverte aux contributions d'académiques, de professionnels et de profanes. La seconde partie de l'article examine les présuppositions normatives de la bioéthique non adjectivale, conçue dans l'esprit de la conception délibérative de processus décisionnel collectif. Elle découle de deux sources normatives. Tout d'abord, des valeurs et idéaux démocratiques, comme la liberté individuelle, l'égalité, la récognition et le respect mutuel, qui ensemble établissent le cadre normatif le plus large pour le débat public sur les problèmes éthiques universellement reconnus. L'autre source normative de la bioéthique non adjectivale, ce sont les doctrines auxquelles les citoyens adhèrent. Ces doctrines constituent les réservoirs de raisons et arguments qui peuvent être examinés dans le débat bioéthique. La bioéthique non adjectivale est donc un discours et une discipline liés aux valeurs et idéaux démocratiques. À la différence de la bioéthique adjectivale, qui se veut universellement valide en construisant ses conclusions sur le fondement de doctrines métaphysiques particulières, la bioéthique non adjectivale cherche à clarifier et résoudre les problèmes éthiques reconnus dans les sociétés démocratiques pluralistes, fondées sur des valeurs et des idéaux moraux comme la liberté individuelle, l'égalité, la récognition et le respect mutuels.

Introduction

It has become customary to think about bioethics as a fundamentally divided, dividing and, perhaps, divisive discipline. Scholarly literature and textbooks are replete with all sorts of ''adjectival bioethics'': utilitarian bioethics, deontological bioethics, Christian bioethics, feminist bioethics, and many more. This suggests the unfortunate perception of bioethics as incapable of offering definitive conclusions [1] of much practical and social importance. If bioethics is only adjectival, it is a practical and, perhaps, theoretical failure. In pluralistic societies, it is no viable alternative to traditional ways of dealing with ethical issues associated with healing and relations between human beings and non-human nature. Moral pluralism within the society is mirrored by the multiplicity of views of bioethicists and plurality of adjectival bioethics.

In what follows, I am going to argue that such perception of bioethics must be rejected because it, first, makes the discipline superfluous in view of the existence of traditions of professional, moral, and religious reflection on life and death issues, problems associated with sickness and healing and caring for the suffering ill, inclusion of non-human animals into the moral circle and responsibilities of humans for their lot, or attitudes to natural environment. Secondly, and most importantly, if bioethics are only adjectival, they cannot respond to the needs of a pluralistic democratic society. The initial reason and impetus that inspired the ''founding fathers'' of bioethics was the lack of theoretical and cultural forms of response to new ethical challenges associated with the diversity of normative proposals for medical treatment and research, and environmental crises, which could help societies develop shared solutions. In order to address the needs of pluralistic democratic societies, and so to develop the original concept of bioethics, it should be seen as ''non-adjectival''. Such bioethics is based on a new kind of intellectual engagement, which is defined by a public discourse characteristic for a democratic society.

Although, as indicated above, bioethics covers multiple topics associated with healing and medicine, research involving human subjects, relations between humans and non-humans, and environmental concerns, my argument will be focused on the ethics of healing or medical ethics. The conclusions, however, apply also to other regions of bioethical concerns. The argument will proceed in two steps. First, I will introduce two distinctions. One is between medical-professional and normative-theoretical and doctrinal perspective on ethical issues that arise in medicine. The other distinction is between bioethics as academic research and instruction and bioethics as public debate. On the basis of these distinctions, I will offer a non-adjectival view of bioethics. It is a two-layer discipline or, perhaps, discourse, which covers both academic research and teaching and public debate which is fuelled by professional, normative-theoretical and doctrinal inputs. The goal of the debate is to clarify publicly recognised ethical problems and, if possible, offer their normative solutions. Non-adjectival bioethics, I shall propose, is normative, occurs on various forums, and engages academics, professionals, and lay citizens.

In the second part of the paper, I will discuss normative presuppositions of such non-adjectival bioethics, which, I propose, should be conceived of in the spirit of deliberative views of public decision-making. Non-adjectival bioethics is animated by two normative sources. One source is such core democratic values and ideals as individual liberty, equality, mutual recognition and respect, which enable citizens of a democratic society to exchange opinions on publicly identified ethical issues. The other normative source of non-adjectival bioethics is doctrines to which citizens subscribe. The doctrines are valuable pools of reasons and arguments that can be examined in the bioethical debate. Non-adjectival bioethics is then a bounded discourse or complex of ideas, commitments, and practices, which allows citizens of democratic societies to clarify and search for solutions of publicly recognised ethical issues. It is in virtue of this boundedness, which is rooted in democratic values and ideals, that non-adjectival bioethics has the potential to clarify and, if possible, answer the ethical problems of medicine and relations between humans and non-human nature recognised in pluralistic democratic societies. Unlike adjectival bioethics, which aspires to universally bind conclusions by building their normative claims upon metaphysical doctrines or to being freestanding, non-adjectival bioethics seeks clarifications and solutions of ethical problems recognised by pluralistic democratic societies, which are founded on such core moral values and ideals as individual liberty, equality, and mutual recognition and respect.

From ethics to bioethics

Western culture developed two main currents of thought on ethical issues associated with healing. The professional current found its expression in ethical instructions addressed to healers. Usually, it resulted from reflections of distinguished members of the vocational group. The second current of thought on ethical issues relating to healing can be found in normative philosophical theories or in the doctrinal treatises of theologians. Since the boundary between normative-theoretical and doctrinal approaches is not necessarily clear and easy to draw, as they often share cultural or ideological sources and arguments [2], they form one, relatively heterogeneous group.

The ethical instructions that came from members of the healing profession reflected an appreciation of the ethical significance of health and disease and risk inherent to their actions. Historically, such instructions took on three main forms: prayers, oaths, and codes of ethics [3]. Prayers were personal. The healer declared commitment to ethical ideals, and asked his god or gods to support him in his efforts. Medical oaths are public declarations — offered to the healing profession or the society as a whole — of commitment to ethical ideals. The healer expects success in the treatment of the sick in return for faithful observation of the professed standards.

Prayers and oaths belonged to ethics of virtue. They did not catalogue desirable and undesirable types of action (if they did, it was rare or secondary) but required physicians to exercise certain traits of character in actions. In this way, they afforded healers a significant liberty in the use of their knowledge, skill, and judgment in particular circumstances. This situation was to change in codes of medical ethics, beginning with T. Percival's code [4], which was ''transitional'' in that it retained many characteristics of the

virtue perspective. A typical code of professional ethics is an ordered set of prescriptions and proscriptions, often made by an authorized group, adopted as expression of ideals and aspirations of the members of the profession, which should be exemplified in their actions [3]. Compared to oaths and prayers, codes (with notable exceptions such as the Code of Medical Ethics of the American Medical Association [5]) tend to be comprehensive and rather detailed to provide instruction for the possibly widest range of types of situations, by specifying types of appropriate responses to them.

Prayers, oaths, and codes of ethics are time-honoured forms of self-regulation, which assumes that in virtue of their experiences healers are capable to both adequately identify the ethical challenges of their activities and to determine appropriate responses to them. However, this way of addressing ethical issues associated with medicine is not suitable for a democratic society at large. Although professional experience can give valuable and unique insights into many ethical aspects of the practice of healing, it is not sufficient to give due consideration to all such aspects or include the outlooks of all parties involved. In a pluralistic democratic society, medicine is a collective effort, which needs the voices of, not only, professionals but also of patients, their families, and other individuals in their capacity as citizens. What is needed to address adequately the ethical challenges in medicine is a wide-ranging perspective on them, an approach that appreciates the existential, social, as well as political aspects and contexts of healing, medical research, organisation of health care and various other issues from the point of view of possibly all parties involved.

Normative-theoretical and doctrinal approaches to ethical problems, which are related to issues of health and medicine, promise such a more satisfactory perspective. Within the normative-theoretical approach, the philosophical and theological discussions of healing are not designed specifically for members of medical professions; nor are they intended as sources of practical instruction. The problems are usually used as illustrations of more general theoretical claims or considerations of particular ethical issues. Sometimes healing is seen as an abundant and helpful source of analogies, examples or case studies. In his analysis of ethics in terms of *techne* Aristotle illustrates his key points with the art of healing ([6], e.g. 1104b, 1112b). Another treatment of ethical problems associated with healing, such as abortion or assisted dying, focuses on questions which are perplexing not only to medical professionals but may also be of interest to anyone: a layperson, a religious leader or a member of the profession. In such a normative-theoretical perspective an issue is recognised as sufficiently important to deserve separate treatment and analysis from the point of view of a normative theory. Although reasoning of such approaches is not necessarily deductive (from principles to decisions), the judgments made are shaped by a specific set and interpretation of moral values. Classical examples of this method are St Augustine's treatment of contraception and abortion ([7], 1.15.17) or I. Kant's discussion of inoculation ([8], 6:424 [548]). A prominent contemporary instance of this approach (in the form of ''applied ethics'') is P. Singer's utilitarian rendering of bioethical problems [9].

The doctrinal approach to ethical questions in medicine differs from the normative-theoretical one in that it proclaims an official (or sufficiently entrenched in a tradition to be seen as such) view of a religious community regarding medical ethics in general or particular issues related to medicine. The ideas contained in doctrinal approaches can be characterised as H.T. Engelhard's content-full morality of friends [10]. A particularly prominent example of doctrinal bioethics is the moral teaching of the Catholic Church. Such bioethics is intended to provide moral guidance not only for members of the religious community at large (e.g. an encyclical letter on reproduction [11]) but also for medical professionals who belong to the community (e.g. an address to Catholic physicians [12]).

Historically, the doctrinal approach is a new phenomenon. Its documents respond to publicly recognised ethical problems, which are brought about by technological or societal changes. They are also voices in public debates on important ethical issues and answers to opinions presented in such exchanges. The combination of the perspective of both lay citizens and medical professionals makes the doctrinal approach unique in that it may seem to supersede traditional professional forms of ethical instruction by placing them in a system of ideas which is intended to interpret society as a whole and the healing professions with it.

Despite similarities, there is an important difference between the normative-theoretical and doctrinal approaches. Doctrinal approaches are intentionally grounded in particular metaphysical or anthropological doctrines with their conceptual apparatuses and traditions. The normative-theoretical approaches are typically intended to be independent of traditions. They do not draw, at least not openly, on a particular tradition *qua* that tradition, acknowledged and subscribed to by (groups of) members of a society. At most, they belong to a tradition of thought but this fact is not conventionally used as a justification of claims. Doctrinal approaches, in turn, are usually proud to belong to a tradition, and this fact is frequently appealed to as a reason in favour of the claims made. These divergent roles of tradition put the two approaches in different relations to metaphysics or anthropology. Recognising that it is impossible to abstract from any metaphysics or anthropology in debates of ethical issues, defenders of the theoretical approach tend to appeal to assumptions which are acceptable to possibly the largest number of citizens, whatever their creed or doctrine. By contrast, the doctrinal tactic pays relatively little attention to the problem of public acceptability of metaphysical and anthropological assumptions, remaining content with their alleged truth. The problem of wide acceptance is seen as less a matter of acceptability to citizens than a question of their education.

The two approaches are located differently in a modern democratic society, which is by nature diverse and pluralistic. The appeal of the doctrinal approach is limited to those who subscribe to a doctrine or tradition. Since it relies on anthropological and metaphysical claims with which such citizens identify, it is also practice-oriented. However, the committing nature of the doctrinal approach makes it an unsuitable basis of clarifications and solutions of ethical problems publicly recognised in pluralistic democratic societies. By contrast, the normative-theoretical stance is usually designed to appeal to all by relying on allegedly less committing metaphysical or anthropological assumptions. However, its arguments, which often require specialised

skills and knowledge, typically speak to limited audiences, even if, in principle, their conclusions can be shared by large sections of society.

A pluralistic democratic society needs a forum, which would be responsive to practical concerns by including the voices of medical professionals, as well as doctrinal and theoretical contributions. Such a forum was devised and proposed to citizens of democratic societies by specialists in philosophy, theology, and various sciences at the beginning of the 1970s under the name of bioethics. Whether it be understood according to V.R. Potter [13] or A. Hellegers [14,15], the constitutive element of bioethics is responsiveness to ethical concerns voiced in a pluralistic society which cherishes such moral values and ideals as individual liberty, equality, mutual recognition, and respect. Its clarifications and solutions are offered for the public as the basis for normative and institutional arrangements and with justifications which are intended to be publicly acknowledged, rather than as moral principles to be followed by individuals in their quest for a good life. This characteristic of bioethics developed further when law entered medicine in such momentous cases as that of Karen A. Quinlan ([16], chap. 11). Accordingly, in its beginnings, bioethics was offered as both academic interdisciplinary research and teaching and a public debate ([17], part III) in and for a pluralistic democratic society. Unlike traditional treatments of ethical issues for the healing professions or society at large, bioethics does not aspire to metaphysically founded authoritativeness. Rather, it is a framework of ideas and normative commitments for an informed ethical reflection and enlightened debate aiming at clarification of publicly identified ethical issues and guidance for the search of solutions that results from such a reflection and debate.

T. Beauchamp and J. Childress' four principles [18] illustrate this change of paradigm of moral reflection in two ways. First, the principles of respect for autonomy, non-maleficience, beneficence, and justice are modified canons set out in the Belmont Report [19] (respect for persons, beneficence, and justice), which dealt with ethical issues arising in research involving humans. The report was prepared by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Its appointment was a characteristically democratic response to publicly acknowledged concerns. The concerns could be appreciated in view of neutrality about universal metaphysical or anthropological truths and against the normative background of such core democratic values and ideals as individual liberty, equality, mutual recognition and respect. The existence and work of the Commission is evidence of the belief, motivated by the democratic values and ideals, in an informed consensual process of setting standards which are expected to structure the ethical thinking of citizens in their various roles: as professionals, academic experts, doctrinal authorities, or lay persons. Although sometimes prompted by diverse concerns and in different contexts of power relations between academics, professionals, politicians and lay citizens, similar bodies were created later in other Western democracies to offer guidance for ethical problems in medicine [20].

Secondly, and more importantly, the four principles are not just new rules of ethical conduct for medical professionals. Unlike traditional accounts known from prayers and oaths, Beauchamp and Childress did not propose an ethics of virtue. Unlike codes of medical ethics, the four principles are not a catalogue of injunctions and proscriptions addressed merely to medical professionals. Nor are they part of an ethical theory from which practical guidance is expected to be deduced. Beauchamp and Childress offered a new perspective on the ethics of medical professions and thinking about the ethics of medical decision making in general and in medicine in particular.

The four principles of Beauchamp and Childress have been criticised many times, often deservedly, and for various sins [21—23]. Yet, despite all attacks, they became a standard (if sometimes unthinkingly practised) approach to medical-ethical issues. A key reason for their popularity is that they are primarily designed to organise ethical deliberation rather than give guidance in action. They do not say what kinds of action should be undertaken in what situations. Rather, they specify aspects of situations that need to be attended to, and so the values that must be recognised. They do not advise the physician or any other decision maker in medicine about what to do but about how to arrive at a well-considered, informed and, possibly, enlightened opinion that will be the basis for the doctor's behaviour in given circumstances. The four principles are standards of deliberation on the values involved, not instructions about how to act.

Obviously, many decisions arrived at in this deliberative process will correspond to those demanded by the norms of traditional medical ethics, such as confidentiality. However, one of their characteristics that make them different from decisions advised by traditional approaches is that they require of medical professionals serious involvement in the decision making processes by drawing attention to reasons for and against possible solutions. This process depends on recognition of the salient features of situations under consideration and balancing the values involved [24]. Such decision-making is immersed in a plurality of values, which requires from decision makers — be they physicians, ethics consultants, patients, or members of their family — the ability to think independently about a particular ethical problem and readiness to take responsibility for one's own decisions.

The four principles presuppose a normative context, which shapes the environment for decision making rather than directly guides decisions and actions. On the level of individual clinical decisions, physicians do not set priorities on their own. With patients and, if necessary, with other stakeholders involved in the case, they enact deliberation about priorities and plans. On the level of social policy, public health, or regulatory solutions, the four principles create a context for standards of medical ethics in its traditional sense.

Although they were developed for clinical and research contexts, the four principles are part of a larger democratic enterprise of bioethics, as it was envisaged by its founding fathers. It is a component of the public discourse on moral issues, which emerged in medicine due to technological, social and political changes. This discourse needs constant supply of ideas and a process, which results in clarifications and solutions of publicly recognised ethical problems related to medicine. The ideas usually come from well-known sources: normative theories, doctrines, and professional ethics, as well as from the beliefs of lay citizens.

The process of discourse is public debate, which relies on the expertise of specialists in such diverse areas as, among others, natural sciences, psychology, sociology, life sciences, medicine, and legal studies.

The public bioethical debate, in which various sources and methodologies are used, takes place on several forums [17,25], the relationships between which had been shaped in diverse ways in different countries ([20], chap. X, [26]). In academia, they include research by specialists of many disciplines and methodological backgrounds, which together expand the field's perspective on ethical issues, rather than narrow it down, as is typical for most other disciplines which emerged in the process of specialisation [27]. Academia encompasses research conducted by specialists trained in various disciplines, seminars, and lectures, both for medical students and health professionals and in other contexts of vocational training. A special place is occupied by self-regulation of medical-professional associations both in the form of codes of ethics and ethical guidelines and recommendations designed for various medical specialities. Another important forum for bioethical discourse is hospital ethics committees that assist decision-making by medical professionals, patients, and their families. A higher organizational level is occupied by the debate at consensus conferences and expert panels. Both can be more specialised, such as consensus conferences organised by the Danish Board of Technology [28] or the experts of the Human Fertilisation and Embryology Authority in the UK; or they may have a broader scope of interest, such as national expert committees (e.g., the US Presidential Commission for the Study of Bioethical Issues), which produce reports and recommendations, which may provide a basis for legislation. Patient organizations are an important bottom-up forum of bioethical debate. They show the public their understanding of the specific problems of the disabled or sufferers from particular diseases (e.g. the Federation of the Amazon Associations of women with breast cancer in Poland), raising thereby public awareness of these problems and drawing the attention of healthcare authorities. The press and other media of communication can also contribute to the bioethical debate by disseminating arguments and ideas, and offering channels for feedback.

The public reason of bioethics

As the discussion above shows, bioethics has not been designed as a modern version of normative-theoretical or doctrinal approaches to ethical issues in medicine, independently of democratic arrangements or for any political order. Such adjectival outlooks belong to particular styles of philosophical reflection on moral issues (e.g. utilitarian ethics) or cultural or religious traditions (e.g. Christian ethics) and often express diverse moral sensitivities or perspectives. Bioethics is not, and from its beginning has not been intended to be, adjectival. It is a complex of ideas, normative commitments, and practices for informed and enlightened reflection and study designed for a pluralistic democratic society.

Bioethics was devised in response to scepticism about the possibility of a universally shared metaphysical, anthropological or moral perspective, even though many of its founders did hold strong metaphysical or religious opinions. ''Adjectival bioethics'' — if they were to be more than a particular worldview, research program or social sensitivity to moral problems that arise in biomedicine, and especially if they were to generate universally binding moral directives — questions the essence of bioethics as a public discourse, whose goal is to clarify publicly recognised ethical problems and arrive at their shared solutions. Adjectival bioethics are modern counterparts of traditional approaches (professional ethics, doctrines, normative theories) to ethical issues that arise in medicine. Adjectival bioethics are different from their traditional predecessors in that they deal with unprecedented, numerous, or large scale issues, which stem from social and technological changes. But their approach remains fundamentally as before. Adjectival bioethics are established approaches (or their variants) to new problems.

Non-adjectival bioethics is not a reflection simply on what is right and good and what can make one's life meaningful and better, but above all on how to organize social life and relations between its participants so that they can realize their ideas of what is right and good and what makes their lives meaningful and better. However, it is not a normative theory that would justify foundational moral claims or a freestanding framework in which such claims are justified. Non-adjectival bioethics operates in a democratic framework of debate with various forums and theoretical and normative positions. It is a collective effort to arrive at an organization of the life of a democratic society, which, recognizing the irremovable pluralism of such a society, does not disregard individuals' or communities' visions of a good life. A key difference between adjectival bioethics and non-adjectival bioethics lies in the fact that the former offer guidance about the right and the good by appealing to a normative theory or to a doctrine, while the latter is a collective attempt, within the boundaries of democratic values and ideals, to provide a normative environment (and limits) for such guidance. Both, therefore, contain moral values and ideals.

Since moral standards are closely related to standards of rationality, in that they help decide what kinds of reasons can be offered to others, bioethics must have its standards of inquiry but it cannot rely on any single perspective, theory or doctrine. If it did, it would not be a suitable framework for the exchange of ideas in a pluralistic democratic society because it would not be faithful to the values and ideals of such society. Non-adjectival bioethics shares some of its contextualism, instrumentalism, eclecticism, and theory-independence [29] with pragmatic bioethics [30,31], which has full citizenship in the debate on publicly recognised ethical problems associated with medicine. Unlike some forms of pragmatism in ethics, which attempt to justify a democratic process of arriving at moral truth [32] or democracy as an epistemically privileged political order [33], and which, therefore, attempt to offer ''justification and encouragement for debate and for taking others seriously'' ([32], p. 128), non-adjectival bioethics presupposes democratic values and ideals and citizens' commitment to them. It is those values and ideals that justify bioethical debate and encourage democratic citizens to participate in it and to take others seriously.

The process of emergence of bioethics in response to the challenges of a democratic society was guided by the values and ideals of a democratic society, such as liberty, equality, mutual recognition, and respect. These values and ideals are the natural argumentative and normative environment of bioethics. Therefore, non-adjectival bioethics is not devoid of moral content [10]. Its democratic moral substance is defined by the standards of clarification of publicly recognised ethical problems, on the one hand, and of reasoning to their publicly shared solutions, on the other. In this respect, non-adjectival bioethics is akin to B. Gert's common morality [34] in that it provides a framework within which problems pertaining to medicine are to be considered and can rule out some solutions to such problems. A central difference between non-adjectival bioethics and Gert's common morality is that the latter is intended as free-standing whereas the former is founded on and structured by the broader normative framework of democratic values and ideals. Accordingly, one cannot engage in non-adjectival bioethics outside of a democratic context.

Democratic society is not identical to a democratic state. Formally, a state can be democratic with democratic values and ideals enshrined in its constitution and laws, and with institutions designed to protect them. And yet, the society can be undemocratic if public life deviates from respect for democratic ideals and values. Such disregard may occur on various levels of interaction. Public officials may decide to ignore the values and ideals of democracy by turning democratic laws and institutions into a façade. Some participants of public life may violate democratic values and ideals by treating others as unfit for the liberty of making their own decisions or for participation in the public debate, as being inferior because of race, age, gender, worldview, knowledge or ability. Others may cynically use the values and ideals to achieve their personal or political goals. Even the best democratically organized state needs citizens — both those who hold public offices and those who are not in such positions — who are committed to, and their actions are guided by, such key democratic values and ideals as liberty, equality, and mutual recognition and respect.

Institutions exist in order to provide an environment for the activities of citizens who are committed to uphold certain values and ideals ([35], chap. 7). Institutions and citizens' commitment to those ideals and values are mutually dependent. Well-organized democratic institutions can support commitment to democratic ideals and values; citizens' commitment to those ideals and values aligns the operations of institutions with those values and ideals. Neither democratic institutions can substitute citizens' commitment to democratic values and ideals, nor citizens' commitment to them can replace institutions which structure respect for those values and ideals. Contrary to some critics [36], democratic society needs the democratic virtues of its citizens to exist and flourish, in the way in which any other kind of society needs them to cultivate its values and ideals [37—39].

Citizens' commitment to such key democratic values and ideals as equality, individual liberty, and mutual recognition and respect, exercised in democratic institutions, provides the argumentative and normative habitat for non-adjectival bioethics, in which it can only survive and flourish. Commitment to the democratic values and ideals plays many roles, becoming the groundwork of the public reason [40], or standards of collective inquiry, of non-adjectival bioethics. First, it constitutes the bioethical debate as a fundamentally deliberative process [41—45]. Lack of commitment to those values and ideals marks refusal to participate in the debate, whereas respect for them makes the debate the appropriate method for both clarification of publicly recognised ethical problems that occur in medicine and for development of their solutions. Naturally, those who are not committed to these ideals and values can also use the debate as an instrument for development of publicly adopted solutions. But they will not see any special value in the debate. They could use the debate to achieve the goals favoured by their doctrines, including solutions to publicly recognised ethical problems, which embody the norms of their doctrines. Such goals and solutions are unlikely, however, to respect the values of individual liberty, equality and mutual recognition and respect.

Secondly, respect for democratic values and ideals regulates the process of democratic debate, in which participants are free to submit proposals for solutions to publicly recognised bioethical problems they consider the best, and support them with what they see as the most convincing arguments. Commitment to these values and ideals requires serious consideration of the arguments offered in the hope that they can help clarify bioethical problems and arrive at their solutions which are best suited to respect these very democratic values and ideals. Of course, a democratic debate does not guarantee that constructive solutions will be achieved. At the minimum, however, the debate can secure continued participation in it of all who are willing to do so by containing the potential for clarification of publicly recognised ethical problems. Accordingly, the debate can give a reasonable diagnosis of divergent views, even in the case of intractable controversies, by identifying sources of disagreements, reasons behind them, and the relative weights of those reasons ([43], p. 43). With respect to intractable bioethical issues, the inclusion of various parties into the debate may be a sufficiently good result [46], being an exercise and evidence of the participants' commitment to individual liberty, equality, mutual recognition and respect.

Thirdly, democratic values delineate the scope of bioethical issues to be debated and the direction of their solutions. The debate makes professional perspectives, normative theories, and doctrines visible in the ''market of ideas''. The goal of the debate is to arrive at solutions for publicly identified bioethical issues, which secure individual liberty and equality, mutual recognition and respect. Due to their commitment to the democratic values and ideals, those who participate in the debate have strong reasons to search for solutions of those publicly recognised ethical problems which do not raise issues of equality, individual liberty, mutual recognition and respect. With regard to the problems which do relate to the democratic values and ideals, participants of the debate will be inclined to avoid solutions, which violate or disrespect those values and ideals. They will be disposed to support solutions which allow citizens to practice professional ethical ideals, normative theories, and doctrines they find most convincing, as long as such practice does not violate the democratic values and ideals.

To reach the goal of the bioethical debate, i.e. to clarify publicly recognised ethical problems and, if possible, develop their solutions or at least to make the normative theories, professional insight, and doctrines visible, the reasons offered in the debate of bioethics may come from various sources. From sciences, professional ethics, dominant culture, normative theories developed in philosophy and theology, and from doctrines accepted by citizens. Such a debate does not rely on a conversational restraint [47], which prohibits participants in the debate from presenting the arguments and reasons that they recognise as valuable from the point of view of the normative theories, professional insight, or doctrines they find convincing. Such a restraint would prevent parties in the bioethical debate from consideration of what they honestly see as well supported or particularly important to them or of possibly serious consequences for the public life. In this way a conversational restraint might limit available modes of reasoning about publicly recognised bioethical issues and the chances for opinion transformation, without which clarifications and solution of those problems cannot be reached [48]. In effect, the restraint might privilege solutions, which are unacceptable to some participants in the debate [49], and thereby violate the very values and ideals of individual liberty, equality and mutual recognition and respect, on which the debate is founded.

Non-adjectival bioethics is not therefore just an arena for presentation of professional perspectives, normative theories, and doctrines or an instrument for their imposition on the society. Nor is the role of professional perspectives, normative theories, and doctrines to provide their justifications for democratic ideals and values in order to reach an overlapping consensus ([50], lect. iv). Professional insights, normative theories, and doctrines are the natural environment for the development of moral sensitivities of individuals and communities. In the bioethical debate they are reservoirs or repositories of reasons to be evaluated from the point of view of the democratic ideals and values. Such a role for professional perspectives, normative theories, and doctrines is limited. They are not to be used to assess proposed or actual solutions of those issues as rational or morally correct. On the contrary, the arguments originating in them and proposed solutions are evaluated from the perspective of the values and ideals of a pluralistic democratic society. The justifications and objections raised in the bioethical debate may therefore be motivated by various (and often discrepant) professional perspectives, theoretical backgrounds, or doctrines. They are not ready-made judgments to be transposed into shared solutions of bioethical problems but inventories of perspectives, value judgments, and reasons, to be tested with democratic ideals and values.

Clearly, these considerations apply to various adjectival bioethics. Utilitarian bioethics, Catholic bioethics, feminist bioethics, and others have an extremely important role to play as sources of considerations and arguments. The richness of their intellectual traditions and depths of insight gives them a vast potential of informing and enlightening the bioethical debate and the whole democratic society. But, again, their job in the public debate is not to organise the process of looking for clarifications and solutions of publicly recognised ethical problems or to adjudicate between proposed or actual solutions. While, therefore, the non-adjectival bioethical debate is free, the criteria of acceptability of solutions of publicly recognised bioethical issues are based on the values and ideals of individual liberty, equality, mutual recognition, and respect.

Conclusion

Bioethics is modest and bounded because it is designed for a particular kind of society, a democratic society. In virtue of this boundedness, it can answer the ethical problems of medicine and relations between humans and non-human nature recognised in such societies. It is defined by democratic values and ideals, such as liberty, equality, mutual recognition and respect, which provide both the conditions of the process of clarification of publicly identified ethical problems and arriving at their shared solutions, and the criteria of acceptability of proposed solutions. Bioethics does not attempt to answer the most fundamental questions of human life and death, the nature of the human being and their life, although, of necessity, it relates to them. As academic research and instruction and as public practice, it does not offer final answers to the notorious questions concerning euthanasia, abortion, etc. It is a complex of ideas, normative commitments, and practices that enables the exchange of opinions for both experts of various specialities and lay citizens.

It does not mean that bioethics does not relate to these most fundamental questions of human life. It does so in two mediated ways. First are the injunctions of professional ethics, normative theories, and comprehensive doctrines, which offer their specific answers to such fundamental questions. In this way, plausible solutions of the fundamental problems appear in the debate. The second way of relating to those questions are the ideological and axiological foundations of democratic society, which delineate which solutions are plausible. The task of justifying these foundations does not belong to bioethics but is left to theory of democracy and the philosophy of law.

It is its boundedness, rooted in the democratic values and ideals, that makes bioethics a genuine alternative in a democratic society to traditional approaches to ethical problems in medicine or to the issues of relations between humans and the rest of nature. An attempt to present a limited perspective (as professional ethics usually do) or a comprehensive theory (in the way normative theories or doctrines strive to) as the whole of bioethics would doom the enterprise of bioethics to failure for a democratic society. What makes it special is that it is non-foundational, bounded, and practice-oriented. It is both an academic study and instruction and public debate in a democratic society. It can therefore offer answers to a limited range of questions and to a limited range of societies — democratic societies; the only ones in which it can exist and flourish.

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