



The Role of Universities in the Construction of Public Reason

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I am very much a philosopher in the mold of John Dewey, whose writings profoundly shaped my thinking about the role of philosophy both in our public life and in the life of the university. For Dewey it was essential that philosophy be pragmatic, practical, contextual, experimental, and reconstructive. What needed "reconstruction" was philosophy itself as well as the larger social problems that defined our cultural and political life. In one essay Dewey wrote:

When it is acknowledged that under disguise of dealing with ultimate reality, philosophy has been occupied with the precious values embedded in social traditions, that it has sprung from a clash of social ends and from a conflict of inherited institutions with incompatible contemporary tendencies, it will be seen that the task of future philosophy is to clarify men's ideas as to the social and moral strifes of their own day (Dewey, 1920).

Taken by itself this passage is obscure. A quick example will help to illuminate its meaning. Much of the history of philosophy is viewed as a conflict among metaphysical systems, theories about the ultimate nature of reality. Dewey's point is that those metaphysical conflicts are really collisions among social values — not abstract, but embedded in specific, concrete social problems that are moral and political in nature. The task of philosophy is to facilitate the development of the social intelligence needed to peacefully, rationally, and effectively address moral/political problems by modifying "inherited institutions" (prevailing policies and practices) so they can be more responsive to "contemporary tendencies" (profound social and technological change) that would otherwise threaten those institutions.

Let me give some examples of conflict — framed by what I believe Dewey had in mind — from my own career as a philosopher whose primary academic interests are medical ethics and health care policy. Very early on (1972) I was advised by a wise nurse that if I hoped to understand the problems of living within medical

ethics on the job, I ought to speak directly with health professionals. In the mid-1970s, I heard repeatedly from nurses of their moral distress caused by needlessly prolonged processes of dying for some of their patients, most often those suffering with cancer. Nurses felt they were being asked by physicians to do things they regarded as brutal and dehumanizing. In contrast, physicians saw themselves as morally obligated to use fully the new tools for life-prolongation that were a product of the 1960s (respirators, intensive care units, CPR, renal dialysis). Also at odds were the wishes of patients and family members and the viewpoints of physicians. Often, patients wanted the right to be "allowed to die." They wanted life-sustaining equipment, such as respirators, to be removed; they felt prolonging a painful death offered insufficient compensating benefit. Physicians strongly resisted such requests, which they saw

as the moral equivalent of killing because they would be the direct and immediate cause of deaths.

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If we put this situation in Deweyan terms, the "inherited institution" is the concept of a natural death. It has something of an ultimate

metaphysical quality about it, as God alone has the right to determine when we die. But then there are those "incompatible contemporary tendencies" — the emergence of life-saving and life-prolonging technologies — that strike us as paradigmatically therapeutic, but that also obfuscate the supposedly sharp, divinely ordained boundary that defines death. What we came to realize is that in this world of advancing medical technology, natural deaths would become increasingly rare and "humanly managed deaths" the norm. Viewed in this light we have what is logically recognizable as a moral and political problem: (1) What are the morally permissible limits of managing the process of dying? Must we (family/community) simply tolerate what appears to be prolonged and pointless suffering by the patient? (2) Who should have the power and authority to define those limits in practice? (3) Should these decisions of weight and finality be resolved through negotiation and deliberation in the privacy of the doctor-patient relationship, or regulated through law and public policy?

Humanistic Perspectives on Death and Dying

Today, social policies and practices are in place with respect to these issues. But in the mid-1970s, these were difficult and divisive matters. As a faculty member at Indiana University-South Bend, I worked with community health professionals to secure a

grant from the Indiana Committee for the Humanities, which allowed us to conduct a series of five programs in each of four Indiana communities under the title "Humanistic Perspectives on Death and Dying." Our primary goal was to raise awareness and understanding of the issues I referred to above, though some committee members hoped a practical response would emerge from these dialogues. Remarkably, a nun in one of the South Bend programs told us about an innovative approach in Arizona for caring for the terminally ill: the hospice. She was an effective and persuasive speaker who educated and motivated that audience. A number of participants worked to create a hospice program in

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South Bend. Community education included a public lecture by one of the founders of the hospice of New Haven, the first in the United States in 1972. Fueled by community enthusiasm, we were able in one year to open the Hospice of St. Joseph County, the forty-second U.S. hospice in 1978. More than 1,500 hospice programs

exist today.

Hospice programs are enormously popular throughout the United States. However, in 1978 hospice programs were not warmly embraced by every segment of the community. Many physicians were suspicious: they viewed hospice either as a naive romanticization of death and dying, or as a subtle and misguided criticism of the medical profession by patient-rights fanatics. Others in the community perceived hospice as quiet or disguised euthanasia. Given the novelty of the institution at the time, these concerns were by no means irrational. We addressed them by securing additional funding for more community education and by launching the hospice program, correctly predicting the good works of the staff would best educate the community.

The success of the hospice program reflected well on Indiana University. Yet, students benefited as well; my hospice experience worked its way back into the classroom in many complex ways. In my medical ethics courses I was able to move beyond dry medical-ethics textbooks and convey a much richer, more socially and ethically nuanced picture of the struggles and successes associated with care of the dying in our community. Several health-policy courses were enhanced by real-world experience. One of the practical political problems we had to address in creating the hospice program was that there were four competing hospitals in the community, any one of which might be motivated to open a competing hospice program for "their" patients. In addition, we had

to run the hospice program. So we solved both problems by asking each hospital to provide a substantial, proportional contribution to support what would be a genuine community resource. This process provided a valuable lesson I could take back to the classroom so students could see real-world applications of coursework and a sense that they could make a very real difference in the world.

Seeking an Agenda for the '80s

Another major undertaking, funded by a grant from the Indiana Committee for the Humanities, was a leadership-

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development project titled "Images and Ideals/Challenges and Choices: Seeking an Agenda for the '80s." I was familiar with leadership-development projects conducted by many Chambers of Commerce; while they have value, they are too narrowly focused. The goal of the project was to create a

cadre of more reflective and critical community leaders who would be capable of giving careful thought to conflicts in moral and social values conflicts inherent in competing policy options. Personal visits to corporate CEOs produced \$20,000 in matching funds for the grant. This valuable learning experience helped to forge connections between the university and the business community through something other than the School of Business.

The two-year "Agenda for the '80s" project comprised about forty participants who represented all sectors of the community: business, organized labor, politics, social service, health care, education, and churches. Identified as "emerging community leaders," they tended to be bright, energetic, reflective, and pragmatic. During the first year of the project, twenty-five evening seminars were conducted. Reading materials and an issue agenda were provided for each session, which focused on providing a preliminary articulation of the value conflicts inherent in a particular policy area. Volunteer faculty from many departments at both Indiana University and the University of Notre Dame facilitated conversation — no experts pontificated. Discussions were lively because issues were real. This, after all, was the beginning of the 1980s, the middle of the energy crisis, in a Rust Belt city with stagflation. Twenty-four community problems were identified in the second year, and responsibility was given to these emerging community leaders to create twenty-four task forces, charged with making recommendations for how best to address these challenges. A volunteer faculty member was assigned to each task force to help with research and writing. Their work was presented at a two-day community conference.

The success of the "Agenda" project depended upon considerable support from the upper administrative echelon of the university. For example, fund raising required permission from the

university to avoid jeopardizing the viability of other projects that sought outside support. Another request was to use the well-appointed Board Room as a site for evening seminars, which provided a "distinguished context" for the project. The project not only demonstrated that the university was a versatile community problem-solving resource; it also supported the academic mission, illustrating to the community the deep value conflicts reflected in the domain of public policy are capable of being rationally assessed and analyzed. "Agenda for the '80s" pointed out that we are not limited to hurling ideological slogans at one another when faced with value-based disagreements.

The "Just Caring Problem"

At Michigan State University, I direct a required two-semester course titled "The Social Context of Clinical Decisions." Its core message is that it is no longer valid that the doctor-patient

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If future physicians hope to protect their own moral integrity, as well as the best interests of their patients, they will develop the capacity to engage in social conversations that develop the policies that affect, very intimately, the

practice of medicine. That is, physicians need to understand the political, economic, and organizational issues that impinge on medicine both on their own terms and as ethical issues. The core ethical issue with which they must wrestle is what I refer to as the "Just Caring problem." That problem is captured in this question: What does it mean to be a "just" and "caring" society (or physician) when you have only limited resources to meet virtually unlimited health-care needs? This is the problem of health-care rationing, brought on by ubiquitous pressures for health-care cost containment. Further, we contend this sort of moral problem cannot be resolved in the privacy of one's own conscience — it must be addressed socially and publicly, through sustained community and professional moral conversation.

For the past fifteen years, the "Just Caring problem" has been the primary focus of my academic research as well as outreach work (see Fleck, 1992, 1994a, 1994b, 1995a, 1996, 2000). As a land-grant

the primary focus of my academic research as well as outreach work (see Fleck, 1992, 1994a, 1994b, 1995a, 1996, 2000). As a land-grant university Michigan State University has strongly endorsed and supported my outreach. The university has an internal grant process, which in 1990 was referred to as the AULEG project, All University Life-Long Education Grants. A \$15,000 grant funded a three-year series of community and professional dialogues around the "Just Caring problem" throughout the state of Michigan.

The basic premise of the "Just Caring" Project was that the need for health-care rationing was inescapable, and that hard choices would have to be made regarding how much we as a society could afford to save or sustain human lives faced with a life-threatening medical crisis. Advances in medical technology continually provide an ever-expanding array of seemingly more

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costly options. To audiences I would emphasize that rationing is not a problem somewhere in the future. We make socially invisible rationing decisions today, typically hidden from public scrutiny. Further, it is often the case that the "healthy wealthy" and politically powerful are imposing rationing decisions on the sick, the weak, the poor, and the

politically powerless. I suggest to audiences that rationing by the privileged appears presumptively morally objectionable, and that it might be morally preferable to arrive at a visible public agreement regarding which rationing decisions we would be willing to impartially decide in advance when we cannot predict our future health needs and accept placing limits on collective health-care expenditures.

In these sessions, I am trying to test the feasibility of a model of community dialogue that philosophers and political scientists refer to as "rational democratic deliberation," as opposed to decision-making determined by market forces, bureaucratic or expert judgment, or interest group politics (see Gutmann and Thompson 1996; Bohman 1996; Bohman and Rehg 1997). Over the years, I have developed literally hundreds of "rationing policy and case scenarios" to provoke and focus discussion in these public forums. On average, I conduct fifty to seventy of these sessions each year. The audiences comprise a broad range of professionals and lay groups.

Rationing Policy and Case Scenario

It is expected by the year 2003 we will have a working model of a Totally Implantable Artificial Heart [TIAH]. The cost of this device with surgery will be about \$150,000. On average, this device will provide individuals with five extra years of life expectancy. About 350,000 individuals each year in the United States alone could benefit from this device, of which 70% are over age 65 and eligible for the Medicare program. STATEMENT: A just and caring society is morally obligated to add the TIAH as a covered benefit in the Medicare program, even though this will add \$35 billion per year to the cost of Medicare (now at \$215 billion per year, and the focus of an intense budget battle over the issue of whether or not prescription drug coverage will be part of that program).

In order to get the conversation going, audience members are asked to respond to the "statement" on a Likert scale. In 1990, a useful addition was an audience response system called REPLY. The REPLY system cost \$30,000 for 150 keypads. The REPLY device is the size of a television remote-control device with a dozen buttons linked by radio wave to a receiver computer and video data projector. Each member of the audience (up to 150) operates a device, so his or her response is private. At the end of a 15-second response period, the computer instantly aggregates responses and creates a bar graph of percentages visible to all participants. It is important to emphasize at the outset the purpose of using these devices is to involve each person in decision making and to have an investment in the ensuing conversation. Another point of emphasis is that moral problems are not solved taking a poll, but by providing good reasons for making moral group judgments. Listening to one another and learning about the rationally compelling considerations of others is how a moral conversation gains momentum and focus. It is also how groups come to revise their views on difficult and controversial moral and policy issues.

The TIAH in Medicare clearly provides a controversial scenario for moral conversations and decision making. The typical response graph is widely divergent. Many participants agree with the statement because they believe limiting access to TIAH would condemn to death people whose lives could be meaningfully prolonged. Further, they argue, failure to provide access to TIAH can be attributed to ageism (i.e., elderly are not worth saving because they are no longer productive, or to "putting a price on human life" (i.e., the rich elderly are allowed to buy additional years of life for themselves while allowing less affluent others to die). Those who disagree with the statement object to the relatively high priority of TIAH; the prescription-drug benefit will help more of the elderly each year, at a lower cost, they contend. Further, they argue, there is a broader injustice at stake. Thousands of non-elderly uninsured individuals will die prematurely of heart disease who could have been saved with this device, if they had the resources. A just and caring society first will ensure that all such individuals

have a reasonable chance to achieve a normal life expectancy before giving the elderly an opportunity to extend their lifespan.

Participants respond to about seventeen to fifty items in a two- to three-hour session, and are encouraged to suggest their own items or variations. The goal is not to achieve closure on any of these issues but to become more sensitive both to the range of moral considerations that pull our judgments in different directions and to critical methods that can be used to assess those

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In summary, I have created a virtually seamless web in my own professional life among teaching, research, and outreach. My performance

in each area is enhanced because of what I have learned from my work in the others. As mentioned earlier, my primary areas of academic research pertain to issues in health care justice and health care policy, in particular the role of rational democratic deliberation in addressing morally and politically controversial issues. My outreach work is conducted in an informal, experimental, social laboratory wherein I can test minor deliberative techniques, as well as the deliberative model as a whole I have developed. I believe my own outreach work is educative in a Deweyan sense of that term. I try to introduce into public deliberation a moral vocabulary, analytic distinctions, and relatively refined perspectives on issues that will improve the quality of deliberation. Generally, of course, outreach audiences lack assigned readings to provide a framework for appreciating what I say in lecture. So I have had to practice becoming succinct and engaging in introducing such material into my public presentations, which in turn, has improved my classroom teaching.

I have easily learned as much from these outreach audiences as I hope they have learned from me. Various audience members have given me more than one hundred cases/problems that have provoked and refined my academic research. The value

of such cases is that they are real, troubling situations for the individuals, and not easily or adequately resolvable by some simple moral theory. This forces me to be deliberate in my own moral theorizing.

The frequency, visibility, relevance, and engaging quality of my outreach efforts with the REPLY technology has attracted the attention of various policymakers who have participated at the state or national level. Consequently, I have been asked on many occasions to serve as a policy consultant for the Kellogg Foundation's Comprehensive Community Health Models project, and a member of the Clinton Task Force on Health Care Reform. For the past four years, I have been a co-principal investigator for a National Institute on Health grant aimed at exploring how rational democratic deliberation can help to address a range of emerging ethical and policy issues related to genetics and reproductive decision making. In each of seven communities we conducted a series of thirteen structured dialogue sessions, which allowed us to see how views evolved through an extended dialogue process. NIH is interested in a non-polling, meaningful, feasible, fair and effective way to engage a broader public in the policy-making process. In the classroom, I tell medical students and undergraduates they have serious responsibilities as citizens to participate in these kinds of civic deliberations and that we are providing them with the necessary tools to do so thoughtfully and effectively. A successful outreach record of public deliberation shows this is not just inspirational rhetoric.

Finally, one of the most important roles universities play in society is that of modeling, motivating, and sustaining respectful, rational, democratic deliberation regarding controversial, complex, deeply divisive moral and political issues. In a culturally diverse, ethically pluralistic society we need a medium for rationally shaping public policy in value-laden matters that can be seen as legitimate from a very broad range of cultural and value perspectives. The contemporary philosopher, John Rawls (1993), refers to this medium as "public reason." My own outreach, teaching, and research efforts have been aimed at helping to create that medium, and thereby carry out one central role of the contemporary university. ■

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His teaching and research focus is in medical ethics, health-care policy, and social, educational, and political philosophy. He has published more than seventy articles, either as book chapters or in various professional journals of philosophy and medical ethics. His major research project is a book, *Just Caring: The Moral and Political Challenges of Health Reform and Health Care Rationing*.

Fleck has directed a number of community-education projects on justice and health-care policy. He is director of the statewide health-reform project, "Just Caring: Conflicting Rights, Uncertain Responsibilities (Citizens Forums for Health Reform)." Fleck is director of the community-dialogue phase of a three-year National Institutes of Health project, "Genome Technology and Reproduction: Values and Public Policy."

In early 1993, Fleck served as a member of Working Group Seventeen, "The Ethical Foundation of the New Health Care System," for the White House Task Force on Health Reform. From 1989-90, he served as the staff ethicist for the Governor's Task Force on Health Reform. He is past president of the Medical Ethics Resource Network of Michigan.