Tougher Decisions:

More Cases

In

Clinical & Medical Decision-Making

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PREFACE:

I find that I have landed myself in the middle of two academic giants, but agree with neither—Normative Ethics, Metathetics, & Applied Ethics.

However, the problem that the study of clinical-decision faces is that of its inherited name family name—“ethics.”

“Biomedical” hits the exact right note; however, it is the word “ethics” that is applied to this concept—this requires the dedication/study/& philosophical insight that has been literally taken for granted since the inception of biomedical ethics.

One might ask why is this problematic? Let me take you far back into your undergraduate training and elicit from you the root word of “ethics;” the genesis of the word may not at first lend much credence to the topic, but continue to consider the top, “Biomedical Ethics.”

Ethics to me implies that someone/individuals are correct while others are not. When making clinical-decision making, at least as part of a clinical-decision-making team one needs to be aware that they (themselves) are viewing the situation thorough the many many glasses through which they have matured.

One individual may come to the table with 8-10 pair of ethical lenses, while another with 5, and another with 50. No one will ever know. The end point is that clinical decision-making should be called just that; no biomedical ethics.

It is now necessary as academicians to realize that simply the word ethics brings baggage to the table—whether one is aware of it or not. An elder black man, who drinks tea each morning, will view a situation in a different manner than a white, woman, with small breasts, and who was raped as a child.

This, this is my rationale for floating this “Pre-White” Paper…. I waned to take the temperature of my colleagues before continuing to write the outline I have developed.

Should “ethics” be taken out of the clinical-decision-making process or do I just need sleep.

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