more likely to experience psychological disorders, suicidal ideation, and substance abuse problems. The APA ignored the massive evidence that the LGBT were not born that way and some of those who sought therapy could change.

While Reilly presents an excellent review of the real dangers of the LGBT agenda, one has to question whether his solution—namely focusing the sinfulness and unnaturalness of sodomy (anal intercourse)—is the answer. He touches on what may be a better strategy, stressing that the LGBT are not born that way and change is possible. Those who

might question these claims would do well to read the very well-documented special report in a recent issue of *The New Atlantis* journal titled “Sexuality and Gender” by Lawrence Mayer and Paul McHugh. The article references numerous well-designed studies, which show that the LGBT claims are not supported by scientific evidence.

Reference

Mayer, Lawrence S., and Paul R. McHugh. 2016. Sexuality and Gender: Findings from the biological, psychological, and social sciences. *The New Atlantis* 50: 4–143.

Death Before Dying: History, Medicine, and Brain Death. By Gary S. Belkin. New York: Oxford University Press, 2014. xxvii + 288 pp. ISBN 978-0-19-989817-6

Reviewed by: Stephen Napier, PhD, *Villanova University, Villanova, Pennsylvania, USA.*
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If a person *is* dead in the medical setting, two consequences follow. First, if the patient has elected to be an organ donor, it is permissible to extract a vital organ that is still functional from the patient. Such an action would not kill the donor since the donor is already dead. A second consequence is that further life-sustaining measures may be withheld or withdrawn even over the objections of the surrogates or family members. The reason is that they are no longer in truth life sustaining. We would no longer be caring for an existent person. Consequently, *accurately* determining death is important so as to avoid kill-ing a patient for transplant or to avoid providing futile interventions.

Because of the advancements in medical technology, however, patients can be kept “alive” in conditions where it may be difficult to discern whether or not the patient is dead. For example, patients who have lost whole brain function irreversibly, may still retain a heart rate without medical supports. It was precisely in the setting of these advancements that spurned Henry Beecher at Harvard Medical School a committee to address the diagnosis and prognostic significance of brain death. The committee published a report in 1968 (Harvard Medical School 1968).

According to Gary Belkin, the prevailing historical characterization of the Report is that it was “ethically unsophisticated, problematically focused on transplantation, and lacking a conceptual

justification and empirical basis for this way of understanding and defining death” (xv). Belkin takes on two tasks, the first of which is to challenge the prevailing historical characterization. The second is to explain why challenging these characterizations is important. On this second task, Belkin wants to say that these characterizations rest on distinctions between 50 “medical knowledge, and ethical expertise over its use; [and] between medical facts . . . and the values implicit in them” (xv). In reply, Belkin wants to argue for a pragmatic epistemology. “Keeping pace with the walking biological creatures that we are requires . . . a pragmatic point of view of medical knowledge, as well as of medical values” (xvii). Belkin seems to endorse a generic pragmatism according to which the goal is “whatever works.”

The chapters that follow, aim to defend the two tasks in rough order. Chapters 1–5 aim primarily to accomplish his first task, and Chapter 6 aims primarily to defend the second. I say primarily because the latter task is scattered throughout, for example, pages 36–40, and 197–200.

The first chapter, titled “Strange Business,” aims to provide a broad setting within which discussions on brain death would occur in the late 1960s. The issues addressed are the developing discussion around what counts as extraordinary versus ordinary treatment; the discussion surrounding truth telling in medical practice; and the developing discussion on research ethics. (It was unclear to this reader how the issues of truth telling and research ethics contribute to Belkin’s overall narrative.)

The second chapter, titled “The Justification . . .” serves, in my opinion, as the heart of Belkin’s first task. He aims to outline the justification for convening the committee in the first place, and in some places he justifies the specific content of the report. Belkin’s skills as a historian of science are on display

chiefly in this chapter and in Chapter 4 titled "Criteria I: The Waking Brain and the Discourse of Consciousness." I found these chapters to be the most interesting of the book partly because Belkin's resources include Henry Beecher's unpublished papers that include marginal notes and comments on other people's critiques of the report; and importantly, medical chart notes by numerous physicians on the forefront of brain science. Chart notes are an important way to understand the thinking of medical practitioners insofar as the reader sees the evidence they saw. Belkin should be commended for bringing into relief this important aspect of intellectual history.

The third chapter is titled "The Law." In this chapter Belkin outlines how certain members of the Harvard Committee presciently prepared for possible legal challenges to their definition of irreversible coma.

As noted, the fourth chapter constitutes part of Belkin's contra-narrative. Specifically, Belkin mines from the pre-1968 discussion on consciousness and brain function a wealth of information. The sources included are quite esoteric, such as research dating to 1836 and Robert Schwab's (a prominent EEG researcher in the 50 s) private papers.

The fifth chapter is titled "The Criteria II: The Working Brain and the Comatose Patient." This chapter continues the detailed empirical story culled from medical chart records and early discussions on the reliability and specificity of electroencephalography (EEG) recordings. Belkin is most clear in this chapter, for why he thinks the prevailing historical characterization needs to be challenged. He says, "brain death, to those who developed the criteria for it, emerges less as a proxy term for permission to withhold care than as an imperative for doing so" (177).

The sixth and final chapter is titled "Brain Death after Beecher and the Limits of Bioethics." The final chapter focuses on Belkin's epistemological concerns, and in particular, he challenges the epistemic arrogance of bioethics.

I do not envy the historian's task. On the one hand, he has to tell a story that includes an etiology for the narrative, its implications, and it must be coherent. On the other hand, he must argue for the narrative as being the correct way to understand things. Arguing for a narrative requires supplying evidence. What makes this task hard is that a simple story, with a few pieces of evidence here and there, is simpler to understand. But such a story would be poorly supported. But to supply a sufficient amount of evidence, complicates the narrative and makes it harder to

understand. Belkin clearly leans to the side of complication, and he seems content with this—as am I. He says explicitly that the history surrounding the development and implications of the report is a complicated history which collates numerous interests, medical developments, and shifting societal norms.

A few minor defects of the work are worth noting notwithstanding my recommendations specified below. One defect, already alluded to, is that it is unclear what exactly Belkin's narrative is in some places. He provides, at times, a recapitulation of an esoteric discussion, for example, his discussion of truth telling and research ethics. But it is unclear what supposed to follow. What is the argument? What conclusions should we draw from those debates vis-à-vis brain death? I suspect Belkin would not consider this a defect at all, since he says repeatedly that the actual narrative, in contradistinction to the prevailing one, is more complicated. This reader wanted the "dots connected" more explicitly.

Another minor defect is that several times Belkin *seems* to conflate a definition of death with a criteria for determining death. For example, he says, "in this shift toward a more neurological definition of death, before the criteria appeared several legal scholars called for such reconsideration of how to define death" (93–4). (See also xiv–bottom). A definition of death aims to define what it would be for a person not to exist. A criteria for determining death would be those features, signs, or markers that would indicate that one's definiens for death is satisfied. A definition of death is an ontological claim, a criteria for determining death is an epistemological one.

Lastly, I found his discussion of medical epistemology insufficiently motivated. Consider the following concluding remark:

The brain, and medicine in general, can be a seductive place for pondering meaning and for resurrecting faith in moral philosophy. Yet, experience with brain death cautions against squandering another generation of resources, including scholarly and policymaker attention. (242)

And a few lines down from this quotation, he endorses a pragmatist epistemology. "They are [problems in neuroethics and brain death] problems that call less for ethical analysis than broad literacy in how the relevant knowledge works or could work" (242).

I found these comments almost selfdefeating. The reason why is that, presumably, knowledge that works is a *good* thing and, therefore, is subject to

ethical assessment. What is more, on a pragmatist theory, what works is teleological. What is good is what accomplishes a particular end. But the pragmatist cannot tell us what is *valuable* about that end without doing ethics. Moreover, I discerned no argument in the book for why moral philosophy has *no* place in assessing whether or not a person is dead. I began my review by noting what exactly is *ethically* at stake in this issue.

In spite of my misgivings, I highly recommend the book for anyone interested in the history of medicine, and the central chapters are necessary reading for those interested in both the medical and historical aspects of the neurological criterion. I found the book very informative and pro-foundly interesting

in so far as Belkin brings into relief how physicians thought about death prior to the legal and medical consensus concerning neurological criteria (National Conference of Commissioners on Uniform State Laws, 1980).

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