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5 The Evidence from Near-death Experiences

Under the heading 'near-death experiences' I include two rather different sorts of data: first reports from people who have been resuscitated from a close encounter with death; and secondly reports collected from doctors and nurses about the death-bed experiences of some of their patients. Let us start by examining what it is that resuscitated persons claim to remember.

According to an editorial in the *Lancet* for 24 June 1978:

'Collected accounts volunteered by survivors . . . bear striking similarities. Amongst the experiences many have described are an initial period of distress followed by profound calm and joy; out-of-the-body experiences with the sense of watching resuscitation events from a distance; the sensation of moving rapidly down a tunnel or along a road, accompanied by a loud buzzing or ringing noise or hearing beautiful music; recognising friends and relatives who have died previously; a rapid review of pleasant incidents from throughout the life as a panoramic playback (in perhaps twelve per cent of cases); a sense of approaching a border or frontier and being sent back; and being annoyed or disappointed at having to return from such a pleasant experience – "I tried not to come back", in one patient's words. Some describe frank transcendent experiences and many state that they will never fear death again. Similar stories have been reported from the victims of accidents, falls, drowning, anaphylaxis, and cardiac or respiratory arrest'.

This summary agrees closely with the accounts given of such experiences in R. A. Moody's *Life after Life*, or J. C. Hampe's *To Die is Gain*, both of which have received substantial coverage in press, television and radio.¹ And readers familiar with their work will be

able to fill out the *Lancet's* summary by recalling their vivid anecdotes especially those relating to supposed 'out-of-the-body experiences', 'encounters' with deceased relatives and experiences of peace and joy. There seems no doubt about the basic authenticity of the experiences reported. M. A. Simpson comments dourly, 'collections of such anecdotes have been widely read, greatly overpraised and misrepresented in their promotional material and reviews'. But he agrees that 'there is indeed a range of interesting similarities among the accounts of their experiences given by [the] victims'.²

The question is how the data should be interpreted. Moody's publisher asserts that the reports are 'actual case histories that reveal there is life after death'.³ Likewise for Dr Elisabeth Kubler Ross these experiences confirm that conscious awareness continues after bodily death.⁴ However this view is challenged by the Editor of the *Lancet* who makes the logical point that 'only a deliberate use of obsolete definitions of death can enable one to claim that anybody has, under clinical conditions, returned to tell us what lies beyond death, for by working definition, periodically updated, death is just beyond the point from which anybody can return to tell us anything'. Professor Paul Kurtz comments, 'we have no hard evidence that the subjects had in fact died. Such proof is not impossible to obtain: rigor mortis is one sign, brain death is another'. What the accounts actually describe is 'the dying process or near-death experience, *not* death itself'.⁵ In part this is simply an issue of semantics. In virtually all these cases breathing had ceased, the heart had stopped beating, and the patients showed no visible signs of life. If that is what one means by the word 'death' (and it is its meaning in common usage) then they had 'died' and therefore required 'resuscitation' (i.e. 'restoration to life') to bring them back to consciousness. On the other hand if the word 'death' is to be exclusively reserved for cases of irreversible brain damage and bodily dissolution, then no one, by definition, could simply be 'restored to life', for the only cases which could then be considered would be better described as examples of physical 'resurrection' (i.e. 'raising from the dead') and this is not the claim being made in these instances. Probably the least question-begging language to use is to talk of 'resuscitation from a near-death experience', or from a 'close encounter with death'. Manifestly all these persons were somewhere near the boundary between life and death and on which side of this border we locate them during their experience is the substantive

issue with which we are concerned. We ought therefore to avoid pre-determining the outcome by a linguistic decision one way or the other, and see whether we can use neutral terminology to explore the data, subsequently deciding which description gives the clearer insight into what was actually happening.

Let us examine first the reports made by patients after resuscitation that at the moment their hearts stopped beating, they found 'themselves' outside their bodies, looking down upon the efforts being made to revive them: The sight of a doctor making ready to administer a life-saving cardiac injection is frequently the last recorded 'observation'.⁶

According to Sir Cyril Burt this phenomenon might have a quite natural explanation. A change of blood pressure in the inner ear can evoke a sensation of rising, hovering and floating in space. This can happen when a person is lying down and when something stops the flow of blood through the body. One might therefore expect that a person whose blood flow was checked by cardiac arrest would consequently suffer a change of blood pressure in his inner ear and have the sensation of rising up into the air and floating in space. Secondly people with vivid powers of optical imagery quite often visualise their own bodies 'and when (as not infrequently happens on critical occasions) the vividness approaches that of an actual sensation, they naturally assume that they have temporarily acquired the position in space from which this visual picture would be obtained'.⁷ Burt describes how a patient who underwent an operation performed under spinal anaesthesia told him afterwards: 'I couldn't help wondering what I must look like to the doctors and nurses bending over my body, and then I actually saw myself lying there on the table . . . I was wide awake, because . . . I started to talk to nurse about it'.⁸ The psychological phenomenon of visualising one's body as if from outside oneself becomes more common when a person is subject to serious emotional stress. According to Drs Druss and Kornfield 'a cardiac arrest is a sudden and frightening experience which calls forth a variety of defense mechanisms' and produces an intense underlying emotion of 'overwhelming anxiety'.⁹ So we can postulate that the stress of cardiac arrest would cause visual hallucinations of an out-of-the-body type. At the same time it seems probable that the cessation of circulation would cause blood pressure to change in the middle ear bringing about a sensation of floating in space. Taken together these two phenomena would seem to provide a full explanation of why we

should expect dying people to fantasise about floating below the ceiling looking down on their unconscious bodies.

No doubt a natural explanation along these or similar lines might do justice to some of the reported cases. Garth Moore describes the case of a person who was convinced that while apparently unconscious undergoing dental treatment he had overheard a conversation between the dentist and the anaesthetist. Both assured him that his account of their alleged conversation was pure fantasy. This case is not strictly comparable to those we are considering in that the patient was neither near death, nor did he have an 'out-of-the-body' experience. But it is 'a warning against too ready an acceptance as veridical of an experience which rests solely on the belief of the person relating it'.¹⁰ Moreover since psychiatric reports indicate that critically ill people frequently suffer from a variety of hallucinatory experiences,¹¹ it would be odd if their delusions did not sometimes take the form of visual hallucinations of the out-of-the-body type.

But one difficulty of applying this type of explanation to all the cases is that many of the patients are uncannily accurate in their descriptions of what was going on while they appeared to be in a state of deep unconsciousness poised on the brink between life and death. Professor Michael Sabom who has followed up many such cases comments that what is particularly notable is the 'great clarity of the patient's consciousness as he looks down at his body from outside, often observing exactly the frenzied efforts of the medical team to revive him'.¹² Dr Kubler Ross relates how people 'describe in magnificent detail the attempts to resuscitate them'¹³ and J. C. Hampe gives several vivid examples of such cases.¹⁴

What is even more remarkable is that many descriptions accord with the claim to have viewed the events from a vantage point other than that of the body on the operating table. Dr Moody comments, 'Physicians have reported to me that they just can't understand how their patients could have described the things they did about the resuscitation efforts, unless they really were hovering just below the ceiling'.¹⁵ Sometimes a resuscitated person describes what was going on in the rest of the ward, despite the fact that the curtains round the bed would have prevented this being visible unless the person 'seeing' all this was higher than the curtains. In one case described by Dr D. M. A. Leggett, Vice-Chancellor of the University of Surrey, a person who had an out-of-the-body experience in a dental surgery afterwards told the dentist, in support

of his claim, that he had noticed two coins on top of a high cupboard in the room. The dentist subsequently 'climbed up to see what, if anything, was on top of the cupboard; there were, in fact, two pennies'.¹⁶ C. D. Broad, R. A. Moody, J. C. Hampe, Lord Geddes and many other writers¹⁷ give detailed examples of other cases where the victim claims to 'see' events associated with his collapse and resuscitation which simply could not have been visible from the position in which the body was lying. And in the cases where verification is possible, these reports are almost always found to be accurate.¹⁸

It remains perfectly plausible however to point out that anyone who had watched programmes about hospital life, or who had spent considerable time in hospital might well possess a basically accurate picture of a resuscitation unit; moreover as Sir Cyril Burt says, when our eyes are closed our picture of reality is 'readily influenced by subconscious impressions coming from the viscera, the muscles and the semi-circular canals';¹⁹ and there is abundant evidence that ability to hear is the last faculty to be lost as we drift into deep unconsciousness. Combining these three factors it could be suggested that a patient's knowledge of the hospital set-up and of his own physical state, stimulated by subconsciously perceived sense impressions and auditory cues, might enable him to visualise a picture of what was going on which was impressively correct. When we further consider that almost all accounts are based on 'hear-say' reports which may have 'improved' in the telling it is still plausible to return a 'not-proven' verdict and insist on further evidence. This may in due course be forthcoming since the Department of Psychiatry at the University of Virginia is systematically collecting reports of such experiences, and perhaps detailed analysis of all the data may throw clearer light on the subject.²⁰

Meanwhile experimental work has been begun on out-of-the-body experiences using carefully worked-out tests to try and verify claims made by some healthy individuals that they can leave their bodies at will. Volunteers are invited to sleep in research laboratories while wired up to instruments which continuously record eye-movements, blood pressure, brain rhythms and the electrical resistance of the skin. Meanwhile a box is suspended from the ceiling containing objects or numbers which are only visible from above.²¹ The idea is that the volunteer should attempt during the night to will himself out-of-his body; notice and commit to memory the time on the laboratory clock; and notice and commit to memory the

objects in the box. Since the box's contents are only visible from the ceiling the experiment, if successful, would tend to confirm the view that the mind can observe from a different vantage point from the body.

These experiments appear to have established that most claims to be able to will oneself out of the body are based on fantasy, since when checked through this type of test the volunteers are unable to fulfil the conditions.²² But there have been two famous exceptions. Dr Charles Tart found a volunteer, known in the literature as Miss Z, who on the fourth night of testing, claimed to have willed herself out of her body and correctly identified a five figure number visible only from above, 25132.²³ Dr Karlis Osis has obtained even better results with a subject called Ingo Swann who during eight trial nights correctly identified all the objects in the suspended box on each occasion.²⁴ What is also extremely interesting is that at the times when the subjects said they were out of their bodies, the instruments to which the bodies were wired recorded absence of the rapid eye movements associated with dreaming, and the 'mean E.E.G. amplitude recorded during the out of the body condition was significantly less than during a non-out-of-the-body condition'.²⁵ Indeed the flattened pattern of brain waves could not be related to any known classification of brain behaviour!²⁶

But 'two swallows do not make a summer', and though these cases are impressive, the hundreds of failures must also be taken into account. One difficulty which these experiments highlight is that out-of-the-body claims which possess some measure of plausibility are extremely rare among healthy volunteers. On the other hand they are very common in the context of terminal illness. As Charles Tart observes 'the surest way to have an out-of the body experience is to almost die'.²⁷ This would suggest that tests with the dying would be far more likely to produce good results than with the living. One way this might be done, would be to paint memorable slogans or pictures on the upper surfaces of, say, the light-fittings in an intensive care unit. If a resuscitated patient subsequently described these markings it would strengthen the evidential quality of his report that he really had been looking down from above on the resuscitation attempts. Clearly the presence of markings visible only from the ceiling would in no way interfere with the urgent medical attention such patients need, and there would be no question of them being 'experimented on'. On the other hand the presence of such markings would provide some kind of yardstick against which

to measure the veracity of any subsequent stories told by the resuscitated.

Susan Blackmore in her pamphlet, *Parapsychology and out-of-the-body experiences*, challenges this whole approach. The reports claim that 'something leaves the body, moves to another location and is there able to perceive'.²⁸ But is this intelligible? 'What could possible perceive . . . except some kind of eye? . . . If the eye is to see it must catch light. If it catches light it cannot be transparent and so it must be visible . . . However such floating eyes are not seen . . . If there is no floating eye then what perceives at the distant location? The only answer seems to be that whatever it is, it does not see by catching light as an eye would do. If it sees by some other means it . . . must be (through) extra-sensory perception (ESP)'.²⁹ But if we are to invoke ESP as an explanation at all, we might just as well postulate that the body on the bed uses some form of ESP, such as clairvoyance, telepathy or precognition to identify the objects in the box suspended from the ceiling.³⁰

I do not see how Miss Blackmore's suggestion helps our understanding of the situation. The case against the supposition that the mind leaves the body and perceives from a different location without using the normal bodily organ of sight is that this notion would be wholly incompatible with any physicalist understanding of the mind-body relationship, and especially with our knowledge of the normal mechanisms of sense-perception. But ESP on the scale envisaged by Miss Blackmore would be at least equally incompatible with the physicalist position, as well as involving further difficulties of its own. Applying her argument to the near-death cases we would have to suppose that the deeply unconscious physical brain of a dying person is somehow able to perform feats of ESP which far transcend the abilities of all the most famous ESP experimenters in good health. Let us try and envisage what it would mean for a brain to use resources which were by definition *extra* to its sensory equipment of perception, and to succeed thereby in 'mimicking localised viewing'³¹ in order to see objects outside the range of its normal viewing powers. When spelt out in full is there in fact any substantive difference between the view Miss Blackmore rejects and that which she accepts? In either terminology the self succeeds in perceiving from a different vantage point from that of the body, and once this is conceded, then talk of 'out-of-the-body experience' seems the simplest and clearest account to give of what is supposedly happening. If the self, by what ever means, is able to

perceive and experience at a distance from the physical body, then it is reasonable to distinguish the self from the body. Hence if genuine perception from a different vantage point can be adequately evidenced it would seem that out-of-the-body experiences are correctly described as such. Yet of course to allow this has enormous implications for belief in a future life, as Drs Osis and Mitchell point out: 'If an out-of-the-body experience literally is what the term implies, that is that some part of personality is temporarily out of the body, then it would be of utmost importance for research in survival after death. If there is something in us which can get out, perceive and act apart from the body, this indeed would make it more plausible that one might also get out at the time of death and continue to exist in one way or another'.³² (Osis and Mitchell are perhaps overstating the case in that evidence for action is inadequate, but with this proviso their argument seems sound.)

Near-death experiences are therefore of the utmost importance to research in life after death, for the evidential features in the reports made by resuscitated persons about their supposed observations provide some of the strongest grounds for supposing that the separation of the self from the body is possible.

A second evidential feature is that those to whom this experience happens become absolutely convinced of the reality of life after death no matter what their previous views were. According to R. A. Moody, 'after his experience a person no longer entertains any doubts about his survival of bodily death. It is no longer merely an abstract possibility to him, but a fact of his experience'.³³ Dr E. Kubler Ross writes, 'Not one of the patients who's had this experience was ever again afraid to die. Not one of them, in all our cases'.³⁴ Moreover after watching hundreds of people undergo such experiences over two decades Dr Ross found her own ideas changing. 'Before I started working with the dying, I did not believe in a life after death. Now I believe in one beyond a shadow of a doubt'.³⁵ John Davy too calls attention to the utter certainty of those who had near-death experiences concerning both its objective character and its profound significance for their lives. He writes:

'These experiences are for those involved as indubitable, or more so, as those in daily life'. Any attempt to explain away the experience by postulating a physiological or psychological account of them 'is to the patients concerned mere incantation. They may keep their experiences to themselves, but privately

they regard such explanations as mere contortions, as unconvincing as most of us would regard the arguments of a solipsist philosopher who explains that the door in which I have just pinched my finger is only an idea in my mind. Furthermore, doctors who are prepared to take note of such experiences, especially those with a "transcendent" dimension, report a consistent and profound change in the attitude to death. The majority of these patients bring back with them an absolute certainty that their eventual physical death will simply be the entry into a mode of further existence that they have already glimpsed. These glimpses are almost always accompanied by a joy and certainty scarcely comparable to anything in ordinary life'.³⁶

It is of course true that profound convictions can be based on delusory evidence and that a person's psychological sense of certainty is no necessary guide to the correctness of his views. And it will be important for us later to look carefully at the suggestions made by competent medical and psychiatric sources about the possible origin of these distinctive experiences. Meanwhile let us simply note that the data of reported human experience will always be an important contributing factor to our understanding of reality, and we need to give particularly serious consideration to experiences which decisively change the beliefs and attitudes of those who have enjoyed them.³⁷

Let us now turn to another element in the characteristic 'near-death experience' namely the reported visions of deceased relatives and friends and of religious figures allegedly 'welcoming' the dying into the life beyond. Clearly these visions are hallucinatory in form and, at least in part, must reflect the religious and psychological expectations of the dying. In the case of adults one might well be tempted to dismiss such reports altogether as of no possible evidential value. But the case becomes more complicated in the case of little children. Dr G. Kliman writes, 'We should make it clear that children up to the age of ten cannot very well understand the concept of death. And the idea of the permanence of death may be as incomprehensible as the idea of infinity'.³⁸ Moreover in the normal course of nature most of the closest relatives and friends of young children are still alive. We know too that in times of stress children frequently hallucinate images of their parents, to whom their thoughts naturally turn for protection.

Dr Kubler Ross works with dying children, many of whom have undergone near-death experiences which they have described to her. She finds it very significant that 'in all these years that we've collected cases . . . not one of these children who nearly died has ever seen mommy and daddy, unless their parents had preceded them in death'.³⁹ Instead the children's visions are exclusively limited to deceased relatives, many of whom they scarcely knew, or to a religious figure like Jesus about whom they had been told. She suggests that this is a strong indication of the evidential quality of these visions, because since children cannot understand death they would not know about confining their visions to the departed, but under psychological stress would see their parents.

This argument will not do. Although children may not understand the full implications of what the word 'death' means, it is perfectly reasonable to suppose that a child can attach meaning to a parental 'explanation' that the reason Granny is no longer around is that Granny has died and gone to live with Jesus. If the child then learns that he too is dying it would be only natural that he should anticipate in his mind a future life with Granny and with Jesus, with whom Granny is apparently now living.⁴⁰

A more substantial form of Kubler Ross' argument however is the claim that in some cases children report having been 'met' by relatives whom they did not know, but subsequently correctly described to their bewildered parents. Dr Ross gives the example of a girl met by a brother who had died before she was born and of whose existence the parents had never told her.⁴¹ Dr Thomas Smith, writing in the GP's weekly paper *Pulse* reports the case of a child met by her grandfather's mother of whom she had had no previous knowledge, but whose photograph she recognised with great enthusiasm when first visiting an uncle's home some time after her recovery. Apparently she had never seen that photo before, nor did any other member of the family possess a photograph of this long departed relative.⁴² If one can accept such testimony, this would indeed be evidence for assigning some kind of objective validity to such accounts. But one's credulity is strained at this point. For it seems remarkably fortuitous that the deceased's self-image, which we are to suppose was communicated to the mind of the child, happened to match an extant photograph taken at one particular stage in her earthly existence.

Fewer problems arise with another type of 'evidential' vision described by Sir William Barrett, FRS. He writes of 'instances

where the dying person was unaware of the previous death of the spirit form he sees, and is therefore astonished to find in the vision of his or her deceased relatives, one whom the percipient believes to be still on earth'.⁴³ Barrett gives eight examples of such cases and Kubler Ross and Allen Spraggett each add another instance.⁴⁴ Dr Ross' case is especially striking since no one at the hospital knew at the time of the vision that the subject of it had died, since his death had occurred only an hour earlier in a traffic accident. Clearly in the context of visions where only the deceased are seen, the reliability of such reports is enhanced when it is established beyond doubt that the percipient had no knowledge that one of those he saw was in that category.

In the light of the discussion so far I conclude that a *prima facie* case exists for treating near-death experiences as evidence for the possibility of personal survival of bodily death. But at this point we must look at the medical and psychiatric background to these cases. Any person hovering between life and death must be suffering profound physical and psychological stress. A brain starved of oxygen, drugged by hallucinatory pain-killers, or excited by fever, is hardly likely to function properly and who knows what visions could be accounted for by its disturbed condition?

One key element in this discussion must be a study of the immediate consequences of heart-failure. We have already seen that checking the flow of blood throughout the body would change the pressure in the middle ear and thus account for the sensation of floating out-of-the-body. Heart-failure would also lead to the cutting off of the brain's blood supply causing oxygen starvation to commence, which without immediate resuscitation would lead fairly rapidly to irreversible brain damage. The first results of oxygen starvation however would be to cause a paroxysmal temporal lobe disturbance. According to Dr James McHarg this would bring about mood changes in the direction of ecstasy and cause visual hallucinations with a religious other worldly colouring.⁴⁵ Clearly this would closely correspond to most of the experiences described.

Likewise many medically accepted drugs used to control pain in the final stages of terminal illness have delusional and hallucinatory effects. This is especially true of the drug ketamine (or cyclohexanone) which is an intravenously injected anaesthetic.⁴⁶ According to Dr R. A. Moody it has side effects which closely resemble out-of-the-body experiences and its after-effects include

hallucinations or very vivid dreams. Other drugs such as the anaesthetic nitrous oxide, or even LSD used to control terminal pain⁴⁷ seriously affect the person's mental and psychological equilibrium.

In addition to these medical factors we must also note the psychiatric evidence presented by Dr Russell Noyes which seeks to explain the near-death experiences as a natural psychological response to the crisis of impending death. He describes them all as the product of 'depersonalisation in the face of the life-threatening danger'.⁴⁸ Noyes' claim is that death threatens all that we are, and it is only natural that the acute stress of this situation would evoke psychological defence mechanisms to shield us from having to face the reality of our own final end. One of these psychological defence mechanisms is the attempt to dissociate our self-hood from the dying body. Noyes comments 'a curious splitting of the self from its bodily representation may occur. Commonly referred to as "out-of-the-body" . . . this splitting represents an interesting negation of death . . . The threat of death is reduced to a threat of bodily annihilation . . .'. By this means, 'the reality of death is excluded from consciousness'.⁴⁹ As death draws nearer, life 'arises to a sharper focus'; 'memories of deceased persons' become 'quite clear and of such intensity as to resemble perception'; and the person rapidly reviews his whole life. This leads to a feeling of self-transcendence and ends with a 'mystical state of consciousness'.⁵⁰ The central assumption of Noyes' argument therefore is that near-death experiences can all be explained in terms of a psychological defence mechanism in order to escape from the acute anxiety and stress of recognising our impending mortality. And this argument is precisely that used by M. A. Simpson who talks of a variety of well-recognised defence mechanisms producing these phenomena.⁵¹

How plausible is the suggestion that near-death experiences could be accounted for by some suitable blend of physiological and psychological factors influencing the minds of the dying at a critical stage? To test this let us consider a massively documented survey of deathbed experiences compiled by K. Osis and E. Haraldsson and published in two parts, a pilot study called *Death-bed observations by physicians and nurses*, and a major work entitled *At the Hour of Death*. Their data differ from those used by Moody, Hampe and Ross in that the reports came from observers of the last moments of the dying, and not from individuals who recovered from apparent death. But there are striking similarities between the two categories

because many of the dying claimed to see deceased relatives 'welcoming' them into the next world just before they actually died.

Osis and Haraldsson based their research on questionnaires completed by over two thousand doctors and nurses in the USA and India about the experiences of their dying patients. The advantage of this procedure was that it ensured that all the data came from trained medical personnel who were in a position to relate any claimed deathbed visions to the known bio-medical and psychological state of the patient, who were familiar with the problems of the critically ill, and who could describe the experiences of their patients in a standard manner so that these could form the basis for detailed computer analysis of the various factors.⁵²

If, for example, deathbed visions were the product of such factors as oxygen deprivation,⁵³ malfunctioning of the central nervous system,⁵⁴ fever, or hallucinatory pain-killing drugs,⁵⁵ then deathbed visions could be expected to be most prevalent when such medical conditions were realised; but no such correlations were found. Similarly if the visions were the product of particular psychological states, or reflected the patient's expectations of death or recovery, then those factors also could be monitored. Once more, no significant correlations could be established.⁵⁶ Of course when the dying patient was under the influence of a medical condition, drug or psychological state which normally causes hallucinations or a feeling of disassociation, he would be as disorientated by it as anyone else would be, if not more so. But the doctors concerned seem to have found no difficulty in distinguishing between such 'normal' aberrations and the distinctive features of the specifically near-death experience. For example hallucinations which followed from a specific medical condition were normally of people still living, whereas hallucinations in the near-death situation were invariably of deceased persons.⁵⁷ The patients were all critically ill of course, and to this extent shared a common condition. Nevertheless one might have expected particular features like oxygen deprivation or stress to have had an influence on the occurrence or non-occurrence of deathbed visions, but no correlations were found even in these two instances.⁵⁸

In short what Osis and Haraldsson's research has established is that all theories which seek to 'explain away' near-death experiences as the product of particular physiological or psychological states break down when one actually looks at the medical records of the people involved. The theories of Noyes or Simpson are shown to

be based on speculation alone and to lack any kind of substantive basis.

Throughout all the discussion I have been writing of 'near-death experiences'. It should however be mentioned that although the class of material seems to be a distinctive body of data, only 15 per cent of people who are resuscitated have a story to tell about their experiences.⁵⁹ Yet doctors actually present in resuscitation wards report that psychological testing of other patients reveals them to have undergone a wide variety of vivid dreams, hallucinations, nightmares and delusions. Indeed the editorial in the *Lancet* which I cited at the beginning of this chapter points out that apart from the type of experiences familiarised by Moody and Hampe, resuscitated patients may suffer experiences of a wholly different kind. Thus 'of male survivors of cardiac arrest, 80 per cent had dreams of violence, death and aggression, such as being run over by a wheelchair, violent accidents, and shooting their way out of hospital only to be killed by a nurse . . . other patients show frank hallucinations and delusions, such as maintaining . . . that they have been in another ward all along, or describing non-existent visits home'. Then there is the 'I am dead' syndrome in which 'survivors of cardiac arrest may for some days claim that they are already dead' and indeed may undergo 'disturbing fantasies about death'.⁶⁰

We must therefore ask whether there are grounds for supposing that the so-called near-death experiences are of any more significance than other fantasies of the critically ill. Dr Maurice Rawlings does not think they are. His book, *Beyond Death's Door*, treats the nightmares experienced by his patients during their operations as being just as significant as any visionary experiences they may subsequently describe. This is rather hard to justify because the survivors of near-death experiences themselves sharply differentiate their 'other wordly visions' from the various dreams and hallucinations some of them also experienced during their illnesses. None of them seems in any doubt that the two types of experience fall into two wholly distinct categories. Dreams, no matter how vivid, life-like or disturbing, will quickly fade from consciousness, unless deliberately recalled and committed to memory at the moment of waking. Real experiences of a vivid kind are, by contrast, normally remembered. The evidence seems to be that dreams and delusions undergone while under anaesthetic or cardiac arrest can be reported on awakening, but are not remembered the following day. By contrast the supposed glimpses of a future life are permanently

remembered and treasured. Even Dr Rawlings' key witness makes this distinction. He has no memory whatever of a nightmare of hell he told Rawlings about during one resuscitation, yet he vividly recalls a vision of his deceased mother and the joy and peace he felt during another close brush with death.⁶¹ According to J. C. Hampe a near-death experience 'cannot be confused with a dream, because it possesses a closeness to reality which dreams never attain. In this experience, as it comes to the dying it is not a question of ideas being lived as they are in a dream; on the contrary it is life that is being thought and experienced. Above all the consciousness of the self is completely different in kind from what it is when dreaming'.⁶² In the light of this, and taking into account the impact near-death experiences have on those who undergo them I suggest they have as much right to be taken seriously as any religious vision or conversion experience which profoundly changes the course of an individual's life.

This reference to religious vision raises the question of how far the near-death experiences are the product of the expectations and beliefs of the percipients. Dr Simpson hints at this in his demand for 'better studies with more careful and less biased collection and interpretation of the data . . . and with cross cultural comparisons . . . to improve our understanding of this data'.⁶³ However important cross-cultural data are already available. One useful survey by Dean Shiels consists of an investigation into beliefs about out-of-the-body experiences in the world's primitive cultures.⁶⁴ This research showed that at least sixty-four out of the sixty-seven cultures surveyed believe in the reality of out-of-the-body states. Conventional theories which have been put forward as explanations of out-of-the-body beliefs (social control, crisis, or dreams), were tested and found not to apply in these cultures. Hence Shiels suggests that the specificity and generality of this belief is simply a response to a genuine event; i.e. the actual occurrence of out-of-the-body experience. 'When different cultures at different times and in different places arrive at the same or a very similar out-of-the-body belief we begin to wonder if this results from a common experience of this happening'.⁶⁵

On the wider issue of the near-death experience as such, the detailed analysis of the data in Osis and Haraldsson's survey shows a remarkable cross-cultural consensus between their respondents in both India and the USA. For although the visions of the next world were inevitably coloured to some extent by the patient's cultural

and religious background, the similarities were much more striking than the differences. It seems that men and women, young and old, educated and illiterate, religious and non-religious, American and Indian, Christian and Hindu, all enjoyed essentially the same types of experience. Moreover, the other-worldly visions did not accord with the traditional belief-systems of either Christianity or Hinduism about the nature of life after death, nor did they accord with western secular assumptions of no such other world existing. All these factors seem to point to the difficulty of accounting for such experiences as projections of the patients' desires or expectations.

Some element of projection must of course be present, for the percipients often claim to see not only departed relatives and friends, but also religious figures from their own particular traditions. Evangelicals often 'see' Jesus, Catholics 'see' Mary, saints or angels, while Hindus 'see' Yama the god of death or other Hindu deities and atheists simply talk of a 'being of light'. But whatever 'entity' is seen it appears to fulfil a similar role and is evidently an important part of many near-death experiences. If there is any sense in talking of 'the religious experience of mankind' one might perhaps expect that any manifestation of the Divine presence would be interpreted within the religious and cultural tradition of the percipient. The problem in the cases we are considering is no different in kind from the general issue of relating descriptions of religious experiences arising in different faiths. And Osiris and Haraldsson's central point about the universality of near-death experiences has been confirmed by more recent findings concerning the deathbed visions of Sikhs and Muslims.⁶⁶

Near-death experiences therefore appear to confront us with data which support the possibility of personal survival of bodily death, and which cannot be accounted for by the physiological or psychological state of the patient, nor by his cultural or religious background. But this conclusion depends upon treating the reports of people like Moody, Kubler Ross, Osiris and Haraldsson as reliable testimony. Is this valid? Up to a point of course the data are undeniable. No one doubts that some dying people have weird experiences. The *Lancet*, the *Journal of Psychiatry*, the International Committee for the Scientific Investigation of the Paranormal, as well as Drs. Noyes and Simpson would all agree that some resuscitated people felt as if they had gone out of their bodies, and also experienced a variety of hallucinatory images. But if we wish to claim that the dying not only had the feeling of being out of their

bodies but actually did go out of them, and that they not merely had hallucinations but had hallucinations which could be supposed to possess some veridical origin external to the percipient, then we move outside the area of agreement. The case for doing so depends at least partly on whether or not we feel that the additional information vouched for by researchers like Moody and Ross is reliable. But is their witness to be trusted?

It has to be acknowledged that with regard to each of the authors there is at least some ground for suspicion. Dr Moody's research is based primarily on a hundred-and-fifty cases he has personally investigated. We have no means of checking how fairly he has presented this information, but in his second book, *Reflections on Life after Life*, Moody cites a 'return from the dead story' from Bede's *History of the English Church and People* which, according to Moody, 'resembles in many respects those heard today'.⁶⁷ However a comparison of Moody's quotation with the original text shows that Moody has made Bede's story fit his scheme, by the simple expedient of omitting all the copious data in Bede which conflict with it. Bede's account seems primarily concerned to describe the torments of hell,⁶⁸ but these are not even mentioned in Moody's version of it. If this case, which is of course the only one readily available for public checking, is a typical example of the way Moody handles his material then this casts serious doubt on his reliability.

What of Dr Kubler Ross, the doyen of all researchers in this area, whose imprimatur in the form of a foreword is sought by all her fellows?⁶⁹ Her international reputation is built on the tremendous impact of her major work *On Death and Dying* which is solely devoted to the proper treatment of the terminally ill. Her contribution to the study of near-death experience is confined to occasional articles and interviews on press and radio. No one can dispute that she has done more than anyone else to improve the care of the dying in the USA, but this does not exempt her work from possible criticism. Walter Kaufmann in an article entitled 'On death and lying' has shown that on occasion 'she makes totally unsupported claims with an air of absolute certainty'.⁷⁰ And her credibility is also called in question by noting how much of the paranormal she is prepared to vouch for. Thus she not only cites evidence of near-death experiences, but also says she has talked with a ghost and persuaded the ghost to write a letter which she has framed on her wall.⁷¹ But that I can't believe. Such a report is not merely contrary to

nature, but also contrary to all that the Society for Psychical Research has discovered in its investigations of 1684 cases of alleged apparitions. Whatever we are to make of such phenomena, one thing is common to all cases ever investigated by the SPR: 'apparitions leave no physical traces behind them'.⁷² Yet if I doubt Dr Ross' veracity on this point, why should I trust her in the rest of her testimony?

This latter problem affects all the other writers I cite: Osis and Haraldsson, Hampe, Spraggett, Ebon, Fiore and Landsburg, Grof and Halifax and most of Crookall's correspondents are all prepared to endorse alleged para-normal phenomena which lie beyond my own personal 'threshold of credulity'. All would agree that a line has to be drawn somewhere, yet once one steps outside the generally agreed limits of a naturalistic world-view, there is no self-evident place at which to draw it.

Despite such doubts I cannot merely brush the data aside. Archbishop Richard Whately once wrote: 'When many coincide in their testimony (where no previous concert can have taken place) the probability resulting from this concurrence does not rest on the supposed veracity of each considered separately, but on the improbability of such agreement taking place by chance . . . For the chances would be infinite against their all agreeing in the same falsehood'.⁷³ In Osis and Haraldsson's survey, the data were collected by two thousand doctors and nurses in America and India; J. C. Hampe's research was done in Germany, and quite independently Drs R. A. Moody and E. K. Ross have each collected hundreds of American cases. More recently, a bibliography of books and articles relevant to near-death experiences has been published, listing two and a half thousand titles.⁷⁴ So one is dealing with a very widespread phenomenon. Moreover, such experiences seem to be far more common than even the published literature suggests, for both Dr Moody and Dr Kubler Ross have commented that whenever they give a talk on the subject at least one member of the audience comes forward with a further case, as I myself have also found when speaking on this subject.⁷⁵ This latter consideration is in the end decisive for my own attitude. Whatever doubts I may have about the methodology of other researchers, I do at least know what I myself have been told at first hand by people I trust, who have had a near-death experience themselves. In all cases such evidence broadly fits into the outlines described by other writers. And therefore, despite the considerations mentioned earlier, it seems

reasonable for me to accept the general veracity of their reports.

If we accept these 'travellers' tales' from the dying as evidential, what conclusions follow? My own view is that if these experiences cannot be related to the particular nature of the patient's terminal illness, nor to his psychological state, cultural background or religious beliefs, and if no other plausible explanation can be put forward, then we have some grounds for accepting them as being what their percipients claim them to be—reports of what actually happens at the moment of death. And what appears to happen is that the soul leaves the body and begins to move on to another mode of existence. Out-of-the-body experiences support belief in the first of these stages, and while there is no direct evidence for the second, (because all our witnesses were 'recalled' before reaching it), it is at least relevant to record the absolute conviction of all the resuscitated that, had they not been brought back, that would indeed have been their destiny.

There is therefore at least some evidence to support the belief in the immortality of the self through bodily death. How, if at all, it may be possible for us to accommodate such data within our overall picture of reality, is a matter to which we must return in our final chapter.