Near-Death Veridicality Research in the Hospital Setting: Problems and Promise

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ABSTRACT: We attempted to conduct near-death veridicality research in the hospital setting, the rationale for which (we presented previously (Holden, 1988).) This paper describes problems, both anticipated and unanticipated, that we encountered. Based on the successes and failures of this undertaking, we present recommendations for future research of this type.

The biggest hurdle in research, it has been said, is the formulation of the research question and the refinement of the research design. Our experience, in the case of near-death (ND) research in the hospital setting, suggests that even the researcher armed with a well-developed question and design faces numerous obstacles. This article describes our experience with research of this type.

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Research Question and Design

Holden (1988) previously presented in depth the rationale for the study undertaken herein. To summarize briefly, the focus was the naturalistic near-death out-of-body experience (nND OBE). In this phase of the near-death experience (NDE), experiencers (NDErs) have reportedly observed the physical environment, usually in the immediate vicinity of, but from a vantage point separate from, the physical body (Irwin, 1985; Ring, 1980; Sabom, 1982). The research question was, "Are nND OBErs' visual perceptions veridical?" That is, do such perceptions match consensual reality?

The research design involved placing visual stimuli in the corners of hospital rooms in which near-death episodes were most likely to occur. The stimuli were to be placed in such a way as to be visible only from a vantage point of looking down from the ceiling. No living person was to know the exact content of the stimuli, thus rendering the design double-blind. Once the patient was resuscitated from a near-death episode in one of the "marked" rooms, knowledge of the content of the visual stimulus would be assessed.

We used for the visual stimuli eight-inch square cards made of picture matting. Each card was one of six colors: red, yellow, blue, orange, green, or purple. In the center was one of six symbols: solid circle, square, diamond, triangle, five-pointed star, or plus sign. Also printed on each card was one of six single digits: 1, 2, 3, 4, 5, or 7.

Six sets of 100 cards each were produced by an artist. Each set contained cards showing one of the colors, symbols, and numbers. The artist had determined the combinations through use of a random numbers table. So, for example, all the blue cards might have contained a triangle with the number 3, all red a square with the number 7, and so forth. She produced these cards in isolation and packed each set in a box. The six boxes were then sealed and randomly numbered.

Meanwhile, card holders had been constructed of white poster board, 9″ square with a ½″ lip all around. Each was mounted with adhesive tabs onto two L-shaped gray metal brackets. The holders were to be mounted in the Emergency Room (ER) and in each room in the Coronary and Intensive Care Units (CCU and ICU). One holder was to be mounted in each corner, as far down from the ceiling as possible without the contents being visible to anyone sitting, standing, or lying in the room.

The backs of all the printed cards were white, and the cards had all been packed face down in the boxes. Thus it was intended that when one chose a box at random and opened it, one would not see the face of

the cards and therefore would not know the visual content of the card. A research associate was to take the box to each hospital room containing holders, at a time when the room was empty and closed, stand on a stool and, while looking away, select the top card from the box, turn it over, and place it in the holder. Thus double-blind criteria were maintained.

Potential subject identification would begin with a member of the Cardiac Review Team. After each weekly meeting, the team member would notify the research associate of any cardiac resuscitations that had occurred that week. The associate would then, if the patient was in sufficient health to be interviewed, approach the patient. The patient would be told that people sometimes remember things that happened during their cardiac arrests, and that whether or not this patient did, the research associate would like briefly to interview him or her. The patient would be informed that the interview would consist of a tape recording of the patient's answers to a few oral questions as well as completion of a brief written questionnaire, all of which would take not more than 20 minutes. Upon agreement, the patient would be asked to sign a consent form. Because NDErs might, during the retelling of an NDE, express strong emotions that could threaten a still-fragile physical condition, the associate was prepared to respond appropriately, including, if necessary, postponement of completion of the interview until a later date.

Consenting patients would first be asked to provide a narrative describing in as much detail as possible any memory of their cardiac arrest and resuscitation. During the narrative the interviewer would not comment if the patient made any references to the cards and/or holders. When the patient was finished, the interviewer would verify with the patient that he or she had related a complete and detailed account.

Once the narrative was completed, the interviewer's first task would be to categorize the patient's near-death episode as either an NDE with nND OBE, an NDE without nND OBE, or not an NDE. The interviewer would ask only as many clarifying questions as necessary to arrive at this categorization, which would not be shared with the patient.

The interviewer's second task would be to pursue patient responses regarding card content. The interviewer would adapt the transition into the structured portion of the interview based on the location of the interview and what had been revealed in the free narrative. For example, if the patient was being interviewed in the same room in which the resuscitation had occurred, but he or she did not make reference to the

holders or cards during the free narrative, the interviewer would point the holders out and indicate that they contained 8″ square cards. If the patient was being interviewed in a different room and had made reference to the cards and/or holders, the interviewer would verify that holders containing 8″ square cards had, in fact, been present at the time of resuscitation. In any case, the patient would then be asked to guess or repeat what was on the face of the card. Patients expressing complete ignorance of card content and reluctance to guess would be encouraged to do so with the explanation that their guess was crucial to the study.

After patient responses to the structured questions had been recorded, the patient would be given a multiple-choice sheet and asked to select one color, one number, and one symbol. The sheet would also ask whether each of the three answers given was a guess about, or an actual memory of, the content on the face of the card.

Cards would then be removed, responses assessed for accuracy, and accuracy figures statistically analyzed. If nND OBErs accurately identified card content with significantly greater frequency than other NDErs and non NDErs, and if double blind criteria had been maintained throughout, the hypothesis that nND OBErs have veridical perception and/or knowledge of visual material through some other paranormal process would be supported.

Finding the Hospital

The first question that arose regarded how best to approach a potential cooperating hospital. At the time, Janice Miner Holden's status as a doctoral candidate in a nonmedical field seemed, in her judgment, to militate against directly approaching medical or administrative hospital personnel. Willing to conduct the research anywhere, Holden wrote to and/or telephoned several professionals active in the field of near-death and psychic research, as well as holistic health. Reactions of those who responded ran the gamut from active discouragement, to interest but inability to help, to yet further referrals, to hearty encouragement. None of these contacts yielded even a potential research site.

Holden then approached hospitals in her own area, the city and suburbs of a major midwestern metropolis. On the assumption that the hospital employee most likely to be sympathetic to the subject of NDEs was the chaplain, one from each of seven different hospitals was contacted, either in person or by phone and writing, over a four-month period.

Four of these involved private hospitals. Chaplains from two of these

hospitals were not supportive. However, a third private hospital chaplain showed great personal interest in the subject because his daughter had had an nND OBE involving apparently veridical perception. A chaplain from a fourth hospital, who was himself a doctoral candidate specializing in Jungian psychology, was extremely committed to assisting with the research, where a good friend of Holden's lobbied heavily on her behalf with the administrative director of this hospital. Despite hopeful beginnings in these two hospitals, the study was disallowed by the administrations of each. The message was quite consistent: Private hospitals were not in the business of conducting or supporting research. In both cases it was contended that refusal would be the outcome no matter who was the applicant or what was the nature of the study.

By the time this message had become clear, three research hospitals had also been contacted. Two were contacted by telephone and correspondence. From one of these, the chaplain reported back that "CCU doesn't want to be bothered" and that the director of research "nearly fell out of his chair laughing" and considered the study "Mickey Mouse."

A chaplain from the third research hospital had been contacted in person. This latter contact was initially encouraging but, upon seeking the support of his colleagues, the chaplain, Leroy Joesten, became discouraged by skeptical or indifferent reactions. However, through his perseverence he arranged an interview between Holden and the director of the Coronary Care Unit. During the interview the director estimated 3–5 cardiac resuscitations per month in the CCU. If our assumption was correct that about 20% of the resuscitants would report an nND OBE (Gallup, 1982; Ring, 1980; Sabom, 1982), then it could be projected that the study in question could be completed in a year or so. The CCU director approved our application to the hospital's Institutional Review Board, and Evaluation and Research Committee. The latter stipulated that no patient be approached until the attending physician's approval had been attained, and six months after the initial contact between Holden and Joesten the study was approved.

Practical Problems

Another six months passed before the study was underway. Some of this delay involved the time needed to produce cards, holders, and forms, as well as selection and orientation of the research associate. Hospital housekeeping staff also had to be instructed not to look at the cards while dusting them.

Joesten initially installed the holders without the cards for a trial run, to identify any unanticipated problems. Shortly thereafter, the research associate found that all the holders from CCU had been removed and were piled up at the nurses' station, as one of the nurses, not knowing the purpose of the holders, had taken it upon herself to remove them all. Up to that point, we had purposely avoided discussing any details of the study with the nursing staff, thinking that the less said, the better, regarding protection of the double-blind criteria. We had expected that questions might be directed to the head nurse or the research associate, who had been coached to explain that the holders involved an ongoing study but to plead ignorance regarding any specifics. But we had not counted on the authoritative initiative of this nurse, and the need for an inservice meeting became apparent.

Consequently, Joesten attended the next CCU nurses' staff meeting, and asked that the holders be left undisturbed. There he learned from the nurses that patients almost invariably asked about the holders. Joesten suggested that the nurses explain to inquisitive patients as briefly as possible that the holders involved ongoing research, that the nurses did not know any details about the study, and that the patients could assume that the holders did not concern them unless they were otherwise notified.

Having dealt with the unanticipated "nurse factor," we were foiled again by the laws of physics. The tabs intended to adhere the metal brackets to the walls would not stick for long to the semigloss painted walls. All holders had to be reinstalled using screws, a method we'd hoped to avoid because of the more costly repair once the study was ended and the holders removed.

Holders were then secured and cards were installed. We had anticipated keeping the cards out of visual range, but had not anticipated the reach of inquisitive visitors. The holder material, flimsy poster board, allowed holders to be bent down and read, thus, cards viewed. Whenever it appeared that someone had tampered with a card, it was changed to one from a different box. This presented a continuing threat to the double-blind criteria and, thus, to the validity of the study. It also complicated the research procedures by requiring the ongoing vigilance of the research associate, a nuisance we had not anticipated.

Results

Contrary to the CCU director's estimate, the first three months passed without a single cardiac resuscitation. In the fourth month, a male patient was resuscitated. His physician approved the interview

but the patient, a recent Armenian immigrant with very poor English skills, declined.

By the end of the sixth month, no more potential subjects had been identified. Curiously, one NDE was known to have occurred during this time, in the delivery room, which had not been included in our study. It became obvious that the study would require far more time than Holden's dissertation deadline would allow. She abandoned the study, but Joesten continued for another six months, during which time there were no reported resuscitations.

Follow-up

Fourteen months after the study had been implemented, a meeting was held to review the study and try to learn from it. In attendance were Holden, Joesten, the research associate, the Cardiac Review Team member (the CCU head nurse), and a CCU staff nurse.

In discussing the lack of subjects, two important points arose. First, the nurses believed that technology had advanced to the point that monitored patients' mild to moderate cardiac arrests could be foreseen and aborted. In these cases there was no need and therefore no opportunity for resuscitation. In cases in which the arrest was so severe that it couldn't be aborted, the chances of successful resuscitation were greatly diminished. This information was reminiscent of a comment made by the ER head nurse during the implementation phase of the study. She had reported that those patients who had not been resuscitated before or during the ambulance ride to the hospital were rarely resuscitated once they arrived; she therefore predicted that we'd have very few if any potential subjects from the ER. Overall, a disquieting possibility is suggested by these findings: that the apparent increased incidence of NDEs that was created by technological developments in resuscitation may soon be reversed in the hospital setting due to further technological advances in the prevention of resuscitatable cardiac arrests.

A second point arose when the nurse disclosed that during the last months of the study there may have been potential research subjects of whom the research associate had not been informed. The team member, whose responsibility it was to report potential subjects, had virtually forgotten about the study due to its inactivity and attenuation. Both nurses expressed the opinion that the identification of potential subjects not be the responsibility of a nurse, but rather of the research associate. It was suggested that records of arrests be coded into the hospital computer, so as to be easily retrieved by the associate on a regular basis.

The need for more thorough inservice meetings with nursing staff was also emphasized. The nurses expressed dismay and even irritation at having been so ill-equipped to answer patient questions about the card holders, and such questions were apparently numerous. Patients were reportedly dissatisfied and sometimes distressed by evasive answers. The idea of explaining to recent resuscitants that NDEs sometimes occur during cardiac arrest was unacceptable to the nurses, who believed that such information could be psychologically distressing and, therefore, potentially physically dangerous to such patients. Consequently, it was suggested that in any subsequent study, every effort be made to disguise or camouflage the holders; if possible they should be made to look like part of the structure or decor of the room, so as not to draw attention and provoke questions. Patients should not even notice them, let alone have their curiosity piqued by them.

A final point addressed a major premise of the study: that cardiac arrest was most likely to occur in the CCU, ICU, or ER. Of all the hospital personnel with whom we conferred in the process of implementing the study, only the ER nurse objected to the accuracy of this assumption. In retrospect, however, the Cardiac Review Team member estimated that as many as 75% of arrests occur *outside of* these areas in the hospital. The nurses suggested two promising sites for future veridicality studies: the cardiac catheterization lab and the electrophysiology lab, which does not exist in every hospital. They suggested that each hospital may be unique in terms of the areas where cardiac resuscitations most frequently occur, leading to the suggestion that this factor be better assessed during the implementation stage of any future research.

Suggestions for Further Research

The difficulty of conducting good near-death veridicality research in the hospital setting is, in our opinion, equaled only by its importance. In addition to those considerations that have grown out of knowledge of visual perception during the nND OBE (Holden, 1989), the research attempt described herein gives rise to others.

The degree to which this study succeeded suggests the following. The researcher would conserve energy by approaching, in person, research hospitals, not private ones. Unless the research protocol involves a more appropriate avenue of introduction into the hospital, the hospital chaplain would be a promising initial contact and potential ongoing research associate.

In addition, the degree to which we failed to achieve our purpose in

this study suggests the following changes. First, the apparent rarity with which in-hospital resuscitations occur portends an extremely protracted study; this may be shortened somewhat by conducting the research concurrently at several hospitals, and by better assessing at each hospital the rooms in which resuscitations from near-death episodes most frequently occur. Second, patients and their guests are likely to notice and ask about research stimuli that appear out of place in the hospital room; they are dissatisfied with evasive answers and will even take investigation of the materials literally into their own hands. It seems imperative that research stimuli take some form that does not attract attention, that in fact seems to be an uninteresting aspect of room structure or decor. Only if this last point is executed with complete success would it be possible to forego inservice training of nursing staff regarding the study. Cleaning staff would presumably still need to be instructed, at least with this particular research design. Finally, the perpetual dearth of subjects calls for perseverence through the prolonged data collection period by a committed, reliable research associate at each hospital research site, one who has direct access to records of recent cardiac arrests. Fulfillment of these considerations of structural change of rooms and long-term salaries for research associates at several sites will undoubtedly require substantial funding.

The hypothesized decreasing opportunity for NDEs that occur during cardiac resuscitations in hospitals indicates that further research of this type should be undertaken with all due haste. Further technological advances in the prevention of mild to moderate cardiac arrest in the hospital setting may so reduce the frequency of NDEs as to render the research unreasonably protracted or even impossible.

The research attempt described herein has left us sadder, temporarily disappointed at the failure of the initial effort and at the likelihood of unavoidable difficulties in future research of this type, but wiser about how to increase the chances of success in future undertakings of this kind. We have maintained our enthusiasm about and belief in the promise of this type of research. We believe the NDE veridicality research, properly designed and conducted, has the potential to add greatly to our understanding of the nature of the NDE as well as the very nature of humans.

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