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Letting Patients and Families Interpret Deathbed Phenomena for Themselves

Nurses and other clinicians shouldn't explain away these often meaningful experiences.

It's an open secret among those of us working with the dying—there's a lot of strange stuff going on for patients, as well as for the clinicians and family members who care for them, that rarely if ever gets talked about: near-death experiences, synchronistic coincidences (stopped clocks at time of death, for example), out-of-body experiences, and visitations from deceased loved ones.

Given our reliance on first- and secondhand report as evidence, it's hard to pin down how many patients or others present at their deaths experience unusual deathbed phenomena. But what evidence we do have suggests that these experiences are common and often go unreported because of fear they will be ridiculed or dismissed. Health care professionals are sometimes among those doing the dismissing. Their explanations can sound authoritative and include electrical activity in the brain's temporal region, oxygen deprivation, carbon dioxide buildup in the bloodstream, the flooding of the system with serotonin or endogenous opiates, delirium, or high fever. Some cite medication adverse effects and others focus on psychiatric explanations such as dissociation, wish fulfillment, or cultural expectations.

It's time we started speaking openly about these occurrences.

While a number of physiologic processes and medications are associated with mental changes, no single factor is adequate to explain them all. The few empirical studies we have of phenomena such as visitations from deceased loved ones suggest that conventional explanations are often at odds with observable facts. In the 1970s, Osis and Haraldsson sent questionnaires to physicians and nurses in the United States and India about their experiences of dying patients. Though reasonable criticisms have been raised about their methods and inferences, the authors concluded from the responses they received that when patients were heavily medicated or suffering from hallucinogenic states related to disease, delirium, or high fever, they were far *less likely* to have deathbed visions than patients exhibiting normal consciousness and oriented to conventional reality.

In a 2010 study in the *Archives of Gerontology and Geriatrics*, Fenwick and colleagues found that health care professionals familiar with end-of-life phenomena are often skeptical of conventional explanations. For example, only about a third of the 38 respondents believed that such experiences were the result solely of "chemical changes in the brain" or were "induced by medication or fever." Fewer still ascribed them to imagination or "psychological unrest or suffering." Sixty-eight percent considered such an experience to constitute a "profound spiritual event."

Despite their prevalence, when these experiences are reported, they're often dismissed, explained away, or left unexplored. Since research suggests these experiences are often personally meaningful and can significantly reduce fear of death, it's essential that health care professionals, especially those working in settings in which death frequently occurs, learn more about such phenomena and become more comfortable in having conversations about what they mean to those reporting them.

Whatever the origins of these phenomena, they appear to be a part of the normal continuum of experiences at the end of life. It's time we started speaking openly about them, creating safe contexts in which patients and their loved ones can share these occurrences without fear of judgment. When people take the risk of doing so, we must resist any impulses to change the subject, impose our own stories, or pretend expertise and authority in such matters. If such experiences are troubling for some patients and family members, we may be able to help them find perspective, and if such events hold personal or transcendental meaning, bringing peace and comfort, who are we to say they aren't real? ▼

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