Teaching Near Death Experiences to Medical Students

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ABSTRACT: Near-death experiences represent for a medical school curriculum a watershed area between life and death, between science and experience, and between the known and the unknown. First-year medical students as nascent scientists and clinicians have complex and often intense feelings about realms that are at the border zones of their developing acumen. In this context, the near-death experience is an ideal topic for teaching professionalism and respect for individual patients, differing cultures, and for colleagues who have differing sets of beliefs. Using videotaped presentations students were asked to explore their own and their peers’ reactions to near-death experiences both in small group discussion format and using a web based discussion board. The inclusion of this topic early in medical school training was felt to be a valuable tool for developing both professionalism and collegiality. It also served to broaden the scientific viewpoint presented in the curriculum in a manner that promoted openness to and respect for patient perspective on life changing events.

KEY WORDS: teaching; medical school; near-death experience.

Near-death experiences (NDEs) are encountered by a substantial proportion of patients and families (Gallup and Proctor, 1982). Patients may turn to physicians for counsel after intense and confusing events that have affected their life views. Many physicians are not equipped, or are unwilling, to provide support and
counsel in areas that lie at the margins of their scientific training (Moore, 1994).

From the vantage of teaching professionalism to individuals who will become physicians, NDEs represent a watershed area where scientific and psychological/spiritual realms interface. It also represents an opportunity to model and explore how we deal with colleagues and patients whose views and experiences are different than our own. From the standpoint of collegiality this model is especially helpful, as it is an area where science has yet to provide a definitive answer. As such, decorum, respect, and interpersonal skills all are paramount in achieving a therapeutic outcome for patients and families and for providing an ongoing harmonious professional environment.

Near-death experiences are a phenomenon that many patients have and will encounter (Greyson, 1998b). Its components have been well documented for three decades (Moody, 1975). Patients may find such events confusing and their reintegration into day-to-day living can be substantially affected by the reactions of family, friends, and medical professionals (Greyson, 1997). Knowledge of areas of patient experience that can have profound impact on world view and well-being are essential for the well-rounded medical professional in virtually all specialties.

Previous attempts to teach NDEs have met with simultaneous strongly positive and strongly negative emotional responses from the student group. This polarization provided for active discussion but resulted in some negative interactions with patients who had come to discuss their experiences with the group.

Goals

An overall goal was to use NDEs as an opportunity to discuss doctor-doctor and doctor-patient professional relationships in an arena where established fact and the medical literature can not provide definitive answers. In addition to this, three other specific goals were felt to be most appropriate for students in their first year of medical school. These were (1) to understand the components of the NDE and that it is a phenomenon well described in the medical literature, (2) to help students understand the life-altering nature of NDEs and related experiences; and (3) to help students develop an approach to realms that are at the borders of medical knowledge
and belief that may nonetheless be important from the patient's vantage.

Methods

NDE teaching was incorporated into an ongoing first-year medical school course that examines and introduces the doctor-patient relationship through presentations by patients and their physicians about their illnesses, their experiences with the medical system, and ongoing care relationships. The course also has a book group component and a required series of in-clinic sessions that are one-on-one teaching sessions with preceptors.

In order to provide a neutral environment for discussion, we presented a videotaped interview of a patient who had an ambiguous NDE. The first year this was shown in class, and the second year it was recorded on digital video disk (DVD) and students were required to watch it prior to the classroom portion of the experience. The patient presented his history of experiencing certain elements of NDEs, including an indistinct otherworldly presence and the feeling of falling or sliding into another realm. He did experience profound life reevaluation and reorientation that lasted over many years. He did not describe it as a classic NDE. There were no negative elements presented, but it also lacked many of the archetypical NDE features. He did lose his fear of death and felt a renewed sense of purpose. He also reported losing many cynical feelings.

Following the video case presentation, we presented a brief overview lecture on the spectrum of patient experiences that comprise typical NDEs. This included information on the prevalence of NDEs and the various components that have shown crosscultural- and age-independent validation in the NDE literature (Callanan, 1994; Greyson, 1993; Stevenson and Cook, 1995). The facets that were mentioned in the lecture included (1) the experience of a profound reality beyond physical existence; (2) the tunnel sensation; (3) the panoramic or sequential life review; (4) the out-of-body experience; (5) being bathed in light or encountering beings of light; (6) seeing or hearing departed friends, relatives, or pets; (7) the sense of peace or cosmic unity; and (8) loss of fear of death.

We also reviewed positive versus negative emotional interpretations of near-death experiences (Greyson and Bush, 1992) and their respective effects on patients' subsequent life, and briefly addressed
neurophysiologic correlates of NDE (Greyson, 1998a; Britton and Bootzin, 2004). Based on debates within the literature and previous polarization during discussion groups, we discussed two models of NDEs (Blackmore, 1996; Bressloff, Cowan, Golubitsky, Thomas, and Wiener 2002; French, 2001; Morse, 1994; Parnia and Fenwick, 2001): (1) NDEs as real-time events that occur subjectively when they are perceived; and (2) NDEs as confabulations secondary to phenomena after the fact, including depersonalization syndromes, hallucinations, hypoxic effects on brain function, and drug-induced states.

The discussion portion of the experience was two-fold. In class the students were divided into groups of approximately six each. In order to foster their sense of collegiality, these groups included students only, without a faculty mentor in attendance. Our faculty group has found in teaching other classes that small-group interaction brings out more individual responsibility and thoughtful reflection and leads to less sniping and cynicism. We asked the groups to discuss the following four questions:

First, do you believe that the near-death experience is a hallucination or distorted perception, or that it represents a separate real-time experience?

Second, if indeed there is a neurophysiologic correlate in the right temporal lobe, is this an artifact of other functions in neurophysiologic architecture, or does it represent the existence of a specific mechanism related to consciousness itself?

Third, for the purpose of discussion, please take the opposite viewpoint from your personal belief. That is, when a patient reports a near-death experience to you, you may be either skeptical of or receptive to this report. If you are skeptical of near-death experiences, imagine that a patient reports a near death experience to you in an office visit following hospitalization. The patient believes that it has profoundly affected his or her life. What is your professional responsibility to this patient and how do you approach him or her in discussion? On the other hand, if you are receptive to near-death experience, imagine that a patient reports the constellation of symptoms consistent with a near-death experience. You are receptive to this and discuss the literature on the subject, but the patient is reluctant to believe anything you say. How do you deal with this patient in a manner that is professionally productive for his or her care, yet provide room for your beliefs?

Fourth, imagine that you are a chief resident making hospital rounds on a medical service and a patient describes near-death experience symptoms. You begin to discuss these with the patient and
the attending physician states vehemently that he or she does not believe that any such thing exists. The discussion becomes somewhat heated. How do you deal with conflict of opinion with a colleague over a topic that is not resolvable through traditional means of scientific inquiry and documentation? How do you interact with the patient in regard to this disagreement?

The second component of the discussion was through a proprietary tool to which our institution has licensed use, called WebCT. This tool allows serial posting by individual students in four different discussion groups for this course, one thread for each of the questions presented above. We incorporated into the log-on process for web access a question asking whether their posts may be used and quoted for the purposes of educational research. We also developed a mechanism to post anonymously for those who wished not to have their entries used in this fashion. Only one student used this option. The advantage of the WebCT tool was that it allowed students to have an extended asynchronous discussion stating their opinions, reflecting on their colleagues’ thoughts, and then posting again after further thought on the subject. It also has the advantage of producing a log that can be reviewed and printed for both teaching and research purposes.

**Results**

The exercise was rated successful in the overall context of the course. The format of discussing the case in terms of professional responsibility kept the process entirely cordial. In previous attempts to teach NDEs, polarization became so intense that some budding clinicians felt their need to define themselves scientifically so focused that they discounted any experiences outside the realm of pure science, and became defensive to the point of making others feel their perspective was not respected. The small-group format and signed posting on WebCT also brought students more into line with developing ways to deal with equanimity with others who have different viewpoints.

It was helpful that the formally presented case involved gray areas at the interface of science and spirituality and not only the NDE itself. The discussion of whether or not the case presented met criteria for an NDE allowed students to focus both on the definition of NDE itself and on the effect upon the patient’s subjective experience and subsequent life. This exercise helped students to understand the physician’s role in being present for someone who has had an intense, life-changing
experience, whether or not an outsider or research-based criteria would label that person's experience a classic NDE. One student posted the comment, "Wow, this is a lot harder than memorizing the insertions of the muscle groups of the back," indicating that the overall process was a success in delineating areas for growth in physicians-in-training. It also put students early in their training in the professional role of having to consider both their own attitudes as they relate to a patient's perspective and their colleagues' beliefs.

Abstracting excerpts from student WebCT postings showed that all three formal goals were well addressed. Students made frequent mention of criteria for defining NDEs, in discussing whether or not the patient in the video did have a NDE. Being unaware of the previous literature on attempts to define NDEs (Greyson, 1999) they also brought forward on their own the tenet that a formal definition would be helpful for research purposes. They posited that having a formal definition with inclusion or exclusion criteria would allow more progress in studying the phenomenon in both neurophysiologic as well as psychosocial terms. The vast majority, however, concluded that for the individual patients it was irrelevant whether they met any outside observer's criteria; what was important was the patient's perception and experience. This was exemplified by the statement, "the patient is telling a truth—whether it is a physical, neurobiological truth or a spiritual, emotional one," and the entry that said, "As a physician, I have a duty to remain open-minded and value my patient's thoughts, especially if these events have a positive impact on the patient's welfare."

The fact that the experience had profound, life-altering effects on the patient's subsequent life was of import to many students in defining this ambiguous video case as an NDE. Many also mentioned that they were also impressed by the fact that it led him to become more focused on the present, more committed to friends and family, less selfish, and less afraid of death. Several said that this caused them to reflect more intensely on their own mortality, an important consideration for those entering the field of medicine.

In regard to patient vantage, many students used the statement that is a strong part of our institutional culture, "the needs of the patient come first," in describing their responsibility to be open-minded and to be of service to the patient. One student wrote:

We must remember how important it is that our patients feel comfortable and supported. Often the topics our patients will discuss with us are some of their most vulnerable moments and the last thing
they want or need is to feel more helpless, ashamed and as though their problems don’t matter/exist.

Another wrote:

It would not be my role as a physician to judge the validity of the event. The fact that it may not have been a “real” NDE is quite irrelevant in the scheme of things. If the patient says the event has changed his/her beliefs and outlook on life, it would be my role to support new-found interests and attitudes and to help the patient move forward since the possible NDE has given way to new life.

The collective discussion was clearly focused on the physician’s role in support and in framing the event in a way that was constructive for the patient’s long-term well-being.

In discussion of the nature of NDEs, of whether they represented a real-time event or an artifact of hypoxia, drugs, and metabolic disturbance, the class was rather evenly split. The discussion was respectful of both patients’ and colleagues’ opinions, but often came down to personal spiritual viewpoints. Comments ranged from, “I don’t find it at all difficult to accept, accounts of simply continued, or heightened spiritual awareness at or near the time of death,” to:

Universally, regardless of societal advancement, religion (whatever form that may be, including atheism) usually provides the most basic explanation for our world. Given that this is the case, it is easy for me to see how in our time of greatest stress (death) we turn to those faiths and our brain begins to produce visions as a way of explaining what we are experiencing.

The subject of how a specific neurophysiologic mechanism could prove adaptive for an individual or population and hence be passed from generation to generation was a recurrent theme. Others posited that at times of altered consciousness, access to other realms of truth were more likely, rather than NDEs being produced by a specific programmed mechanism.

In regard to conjecture about the nature of NDEs as related to underlying neurophysiologic architecture, one student compared NDEs to the visualization function of an MP3 player, in which a system designed to play an auditory program is translated into a visual format. He went on to write:

This could apply to an internal universal experience brought on by metabolic derangement – the underlying physiology leads to activation of a typical pattern of emotional and imagery areas. Or it could
also apply to access to the transcendent through a system that is able to experience this realm but not in a clearly defined or interpretable manner.

Discussion

From a faculty standpoint the exercise was successful on multiple levels. It required the students to take on a professional role mindset at the outset of their training in discussing a potentially charged topic. The format required them to interact cordially with colleagues and to consider how they would treat patients who had viewpoints on important topics that were different from their own. This opened broader discussions of physician role responsibility.

Some students expressed frustration that they had a hard time telling if the individual in the case study did or did not have an NDE. But from a teaching standpoint this was found to be very helpful, as it refocused student discussion from the strident scientific standpoint to a patient-centered approach to understanding their role in dealing with patients who have had profound life experiences. The decisive factor in deciding that the exercise was worthwhile was one student’s conclusion that the exercise helped them to focus on the broader physician role of healer, understanding that it includes, but is broader than, the role of scientist or skilled technician.

References