Study of Perception in Autoscopic NDEs

To the Editor:

In "'Does Paranormal Perception Occur in Near-Death Experiences?' Defended," Keith Augustine charged that in a study I reported in my book *Recollections of Death* (1982), "Sabom did not use the proper control group" (Augustine, 2007, p. 268). This study was designed to address the question: Did "thirty-two people (reporting an autoscopic NDE) have sufficient knowledge of the resuscitation procedure *prior to their NDE* to construct a plausible approximation of their near-death crisis even without having observed it from their purported out-of-body location?" (Sabom, 1982, p. 83, italics added). Here is the description of that study:

> Twenty-five "control" patients were interviewed whose backgrounds were similar to those reporting autoscopic NDEs ... and who had been

consecutively admitted to a coronary care unit (CCU). These twenty-five controls were seasoned cardiac patients with an average duration of known heart disease exceeding five years, including prior cardiac-related hospitalization for a heart attack (20 patients), heart catheterization (12 patients), open-heart surgery (8 patients), elective cardioversion (2 patients), cardiac arrest without an NDE (4 patients) and cardiac pacemaker implantation (1 patient). While in the CCU, each of the patients had had the opportunity to observe closely at his bedside a cardiac monitor to which he was attached, a cardiac defibrillator, and intravenous needles and equipment. Moreover, each patient had admitted to regular viewing of a home television set prior to this admission. Thus this group of twenty-five cardiac patients had received considerable exposure to hospital routine and television programs, both of which could have contributed to their knowledge of CPR.

During the interview, each patient was asked to imagine that he was standing in the corner of a hospital room watching a medical team revive a person whose heart had stopped beating. He was then asked to describe in visual detail what he would expect to see in such a situation. He was cautioned to describe only those details that he was reasonably confident would actually be seen during CPR on a hospitalized patient. Each of these interviews were tape-recorded and later analyzed.

Twenty-three of the twenty-five interviewed patients made some attempt to describe the CPR procedure based on their own general knowledge of hospital equipment and protocol. Without undue prompting, twenty of these twenty-three respondents made a major error in their descriptive accounts. The most common error was the belief that mouth-to-mouth breathing would be the routine method of artificial ventilation in the cardiac-arrested, hospitalized patient. In truth, mouth-to-mouth breathing is a rarely used means to oxygenate a patient during in-hospital CPR because of the rapid availability of alternate, more efficient methods of artificial respiration . ...

Additional errors in these descriptive accounts included misconceptions (by separate patients) of the oral airway used to ensure an open air passage during CPR ("They would use wooden throat paddles, like an ice cream stick, only bigger"); misconceptions of cardiac massage ("a blow to the back to start the heart beating again," "opening up the chest to place the hands around the heart and massage it," "a hard blow to the solar plexus to get the heart started again," "the doctor doing the pushing on the chest would straddle the patient over his thigh region and push up"); misconceptions of cardiac defibrillation ("electric shock would be given through those wires which are fastened onto the chest and hooked up to the cardiac monitor," "the electric shock would be given through a needle stuck in the heart through the chest"); and misconceptions about the defibrillator paddles used to deliver the electrical energy to the chest ("they would be hooked up to an air tank and pressurized," "they would have a suction cup on the bottom of them," or "they would not be hooked up to anything").

Three of the twenty-five patients gave limited descriptions of CPR procedure which were without obvious error. One patient was able to

> describe the cardiac defibrillator present in his room at the time of the interview ("that machine over there") but had no concept of the technique of external cardiac massage, artificial ventilation, or other CPR procedures. Another patient had watched his father's resuscitation in a hospital emergency room and recalled the following scene: a "doctor pushing down on his [father's] chest, center of the chest, with one hand on top of another and sweat pouring off" and "something going in his [father's] arm, with a nurse holding up some sort of liquid in a bottle." The third patient had watched his roommate being resuscitated in the surgical intensive care unit during a previous hospital admission: "the doctor was pressing down on the chest, one hand over another" and the defibrillator was "a big square machine with two pad-looking things with wires on them." This last patient was unable to describe how those "two pad-looking things" would be used on the patient and did not comment on artificial ventilation or use of needles or injections. ... [T]wo claimed no knowledge of CPR technique whatsoever. (Sabom, 1982, pp. 84–86)

Since the in-hospital experience of patients in the control group was similar to that of autoscopic NDErs prior to their NDE, this study correctly offered "some insight into what an 'educated guess' would be" (Sabom, 1982, p. 86) of CPR procedures by the NDErs prior to their NDE.

Augustine (2007b, p. 268) claimed "that corroboration for the specific details unique to the NDErs' own resuscitation was lacking in Sabom's study" (2007b, p. 268), based upon the following quote from Michael Potts:

> Without the details of the resuscitation in the medical records, which often leave out the specific details of procedures used, there is no accurate way to check a patient's account to determine whether it is accurate ... If there were cases of NDEs in which patients recalled visual information that could only been learned by actually being outside the body, such as recalling specific details of the clothing worn by the code team, specific details of the resuscitation including the order of events, or details of the room in which the resuscitation occurred that could have only been learned by actually being there, then this would support the out-of-body interpretation of NDEs. ... but such evidence is lacking at present. (Potts, 2002, pp. 250–251)

Augustine then added: "If there were evidence of the sort Potts outlined, then the data would contradict my critique of near-death veridicality studies; but, as Potts also noted, anything of the sort has yet to happen" (2007b, p. 269).

In a lengthy section of *Recollections of Death* entitled "Autoscopic Descriptions with Specific Details" (Sabom, 1982, pp. 87–115), I

presented interviews with six NDErs who recalled specific visual details of their near-death crisis events, including the placement of an oxygen mask, chest thump, external cardiac massage, insertion of an oral airway, lubrication of defibrillator paddles, placement of defibrillator paddles, charging of the defibrillator machine, movement of hospital personnel away from the bed, movement of the dials on the defibrillator machine while being charged, body response to defibrillation, injection of intracardiac medications, checking for pupillary response, palpation for carotid pulse, insertion of a subclavian vein catheter, and drawing of arterial blood gases from both the femoral and radial artery.

When these NDE reports were compared to the medical record (which specifically documented many of these details), to third party testimony, and to advanced cardiac life support protocol, the content and sequence of CPR details were found to be extremely accurate and case-specific. In addition, one patient identified during an autoscopic NDE the unexpected arrival of three family members at a distant hospital location during his cardiac arrest. The accuracy of this man's report was later confirmed in separate interviews with family members (Sabom, 1982, pp. 111–113). None of the errors made by control group patients were reported by NDErs. A traditional explanation for the accuracy of these NDE accounts was sought but not found (Sabom, 1982, pp. 113–115, 151–178).

If the autoscopic NDE is a true "eyewitness" account, then an analogy can be drawn between an eyewitness to a crime and an NDEr's visualization of CPR. In both situations, the person is afforded a brief glimpse of an unexpected and unfamiliar scene under stressful circumstances which frequently involves a "weapon" (a gun or knife in the case of a crime; a threatening instrument or procedure in the case of CPR).

Crime research has shown that witness confidence in the report correlates positively with the accuracy of recalled details (Bothwell, Deffenbacher, and Brigham, 1987). In my study, high confidence (for example, "it was realer than real," "clearer than normal vision," "this is no figment of my imagination") correlated positively with high accuracy of autoscopic NDE reports, compared to "reasonably confident" control group reporting, which correlated positively with inaccurate reports.

Crime research has also found that witness identification of the perpetrator of a crime in a lineup falls from 56 percent to 35 percent when a weapon is present. The weapon itself is accurately identified

91 percent of the time. This variance is due to a "weapon focus" phenomenon, with the weapon acting as a "salient-object attention distracter" (Kramer, Buckhout and Eugenio, 1990). In my study, details recalled in an autoscopic NDE were heavily weighted, as in crime scene reports, toward "salient object attention distracters," and in both situations such "attention distracters" were accurately described. Thus, the nature and content of NDE autoscopic accounts resemble those of true eyewitness reports.

Taken together, these results support the patient's claim that nonordinary perception of real events (that is, an autoscopic NDE) had indeed occurred.

References

Augustine K. (2007). "Does paranormal perception occur in near-death experiences?" defended. *Journal of Near-Death Studies, 25*, 261–283.

Bothwell R. K., Deffenbacher K. A., and Brigham J. C. (1987). Correlation of eyewitness accuracy and confidence: Optimality hypothesis revisited. *Journal of Applied Psychology, 72*, 691–695.

Kramer T. H., Buckhout R., and Eugenio P. (1990). Weapon focus, arousal, and eyewitness memory: Attention must be paid. *Law and Human Behavior, 14*, 167–184.

Potts M. (2002). The evidential value of near-death experiences for belief in life after death. *Journal of Near-Death Studies, 20*, 233–258.

Sabom M. B. (1982). *Recollections of death: A medical investigation*. New York, NY: Harper and Row.

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