

# Corroboration of the Dentures Anecdote Involving Veridical Perception in a Near-Death Experience

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**ABSTRACT:** One of the most striking examples of near-death experience stories is the account of a clinically dead patient whose dentures were removed from his mouth prior to resuscitation, and which dentures were then lost. Days later the patient saw a nurse and told him that it was he who had removed those dentures. The patient was right, but he should not have known this information, because at the time the nurse had removed his dentures, the patient was clinically dead. Since publication of this account in a prestigious mainstream medical journal, speculations have abounded. In this article I describe the investigation I undertook to put these speculations to rest and the outcome of that investigation.

**KEY WORDS:** near-death experience; out-of-body experience; veridical perception; cardiopulmonary resuscitation.

One of cardiologist and near-death researcher Pim van Lommel's favorite anecdotes about a near-death experience (NDE) is the story of the comatose patient who was brought into a Dutch hospital and whose dentures were removed from his mouth and subsequently got

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lost in the chaos of the resuscitation process. Here is how van Lommel and his colleagues reported this anecdote in their 2001 *Lancet* article:

During a night shift an ambulance brings in a 44-year-old cyanotic, comatose man into the coronary care unit. He had been found about an hour before in a meadow by passers-by. After admission, he receives artificial respiration without intubation, while heart massage and defibrillation are also applied. When we want to intubate the patient, he turns out to have dentures in his mouth. I remove these upper dentures and put them onto the 'crash cart'. Meanwhile, we continue extensive CPR. After about an hour and a half the patient has sufficient heart rhythm and blood pressure, but he is still ventilated and intubated, and he is still comatose. He is transferred to the intensive care unit to continue the necessary artificial respiration. Only after more than a week do I meet again with the patient, who is by now back on the cardiac ward. I distribute his medication. The moment he sees me he says: "Oh, that nurse knows where my dentures are". I am very surprised. Then he elucidates: "Yes, you were there when I was brought into hospital and you took my dentures out of my mouth and put them onto that cart, it had all these bottles on it and there was this sliding drawer underneath and there you put my teeth." I was especially amazed because I remembered this happening while the man was in deep coma and in the process of CPR. When I asked further, it appeared the man had seen himself lying in bed, that he had perceived from above how nurses and doctors had been busy with CPR. He was also able to describe correctly and in detail the small room in which he had been resuscitated as well as the appearance of those present like myself. At the time that he observed the situation he had been very much afraid that we would stop CPR and that he would die. And it is true that we had been very negative about the patient's prognosis due to his very poor medical condition when admitted. The patient tells me that he desperately and unsuccessfully tried to make it clear to us that he was still alive and that we should continue CPR. He is deeply impressed by his experience and says he is no longer afraid of death. Four weeks later he left hospital as a healthy man. (van Lommel, van Wees, Meyers, & Elfferich, 2001, p. 2041)

It was only a matter of time before someone would pick out this anecdote and criticize it. The first such critic was Christopher French (2001):

An OBE can be defined as an experience in which a person seems to perceive the world from a location outside the physical body. One such anecdote was reported to van Lommel and colleagues during the pilot phase of their study by a coronary-care-unit nurse. Unfortunately, they do not report whether any attempt was made to corroborate details with the patient. On many previous occasions such attempts at corroboration have revealed that the evidence was not as impressive as it initially seemed (Blackmore, 1993). Blackmore

(1996, p. 780) lists several alternative non-paranormal explanations as to why people may sometimes seem to accurately describe events occurring during their NDEs. These include “information available at the time, prior knowledge, fantasy or dreams, lucky guesses and information from the remaining senses. Then there is selective memory for correct details, incorporation of details learned between the NDE and giving an account of it, and the tendency to tell a good story.” (p. 2010)

Given the facts that have been unearthed about this case, described below, it seems that both French and Susan Blackmore were wrong as far as this case is concerned.

Other authors published critical responses to the anecdote, but the one that struck me most was the critique that Dutch-Australian anesthesiologist Gerald Woerlee wrote in this *Journal*. Although he had not seen the original document, he explained the denture anecdote as follows, after first telling readers why he thought that all NDEs could be explained in terms of conscious observations by the patients:

Knowledge of all these things makes it possible to explain the veridical experience cited above (van Lommel, van Wees, Meyers, and Elfferich, 2001). The patient van Lommel and colleagues described was conscious as a result of efficient cardiac resuscitation. He could see and he could hear, because when resuscitation is this efficient, the senses of hearing and sight are restored. The residual effects of extreme oxygen starvation on his brain paralyzed him, making it impossible for him to move or speak, so he was unable to tell those resuscitating him to continue. The effects of oxygen starvation meant he felt no pain, and also aroused his OBE. He felt his dentures being removed, and he heard them being placed in a metal drawer; a metal drawer opening and closing makes a very typical sound, and metal bedside cabinets are standard hospital furniture in The Netherlands. His eyes were partially open, or were opened every now and then to check pupil size as an indication of brain oxygen starvation; so he was able to see his brother [that is, the male nurse] and others in the room. This is why he was later able to recognize people, as well as to describe the room. In addition, the sounds and the movements heard and felt during resuscitation also aided him in building a composite picture of all that happened during his resuscitation. After awakening, he was able to tell a composite story of all that happened during his resuscitation. So this ostensibly supernatural experience is actually readily explained by the functioning of the body, together with conscious and unconscious observations. (2004, p. 247)

Again, as with the statement by French, quite probably Woerlee is, at least partly, wrong.

In the Summer of 2007 I received an e-mail from Ruud van Wees, one of the four authors of the *Lancet* article, and also one of the five founders of Merkawah. He told me that he still had under his care a set of folders containing documents such as NDE stories and also the original interview with the nurse who had taken care of the patient whose dentures were removed while being resuscitated. Because all these materials are part of the archives of Merkawah, they had to be returned to the Board of Directors and stored under their responsibility. So I collected all those papers from van Wees and later took the opportunity to study the denture story carefully. As a result, I was able to provide the following corroboration of the denture story.

### Two Documents

The anecdote as published in *The Lancet* was based on two documents. The first document was an article dated August, 1991, and written by Vincent Meijers, the third author of the *Lancet* article (van Lommel et al. 2001) where his name appeared as Meyers. He based the article on an interview he had conducted with another nurse who was aware of the reanimation procedure of the patient whose dentures had been lost. Meijers's focus in this paper was NDEs in general, and he made only brief reference to the denture anecdote.

The second document was an interview transcript dated February 3, 1994. Ap Addink (A.A.), at the time a staff member of Merkawah Foundation who specialized in doing in-depth interviews with NDErs and other people, conducted this interview. On February 2, 1994, he spoke at length with the nurse who had removed the patient's dentures; at the nurse's request to protect his privacy, I will refer to him as T.G. The result was a densely typed document of 12 pages that contained a highly detailed account of what exactly had happened during the resuscitation of the patient, whom I will designate as B.

What follows are the most relevant parts from this interview with T.G., who stated that the experience he related was the most extraordinary one he had ever come across, so much so that he remembered every detail of it. It was also memorable because it happened during his first opportunity to act as the lead person of the first-aid cardiac arrest team. The strength of T.G.'s memory was borne out during the interview as A.A. asked him several times to repeat his account of certain parts of the entire event. There were virtually no differences, and T.G. told the story soberly, with the relevant details

only, and without embellishment. It should also be noted that prior to the dentures incident, T.G. had had some knowledge of near-death phenomena, because he had encountered patients who had told him about their NDEs during his nightly rounds as a nurse. However, he had never experienced an NDE himself nor encountered an NDE resulting from his own treatment of a patient.

### **Woerlee's Explanations Versus the Facts**

Following is a comparison of Woerlee's explanations and the facts as T.G. stated them. I present excerpts from A.A.'s interview with the nurse T.G. as translations from the Dutch original in which A.A. conducted the interview.

#### *Was the patient conscious?*

Woerlee wrote: "The patient van Lommel and colleagues described was conscious as a result of efficient cardiac resuscitation. He could see and he could hear, because when resuscitation is this efficient, the senses of hearing and sight are restored" (2004, p. 247). Was this patient indeed conscious? Here are the facts according to T.G.:

T.G.: I was on duty during a night shift, and together with two colleagues I was waiting for a patient who had been found in a meadow late at night, and who apparently had been lying there for a very long time. When the ambulance arrived the man had no pulse, was not breathing, and seemed clinically dead. But whilst not knowing how long the man had been lying there and also looking so young, the ambulance personnel had decided to start reanimation. Within half an hour he was brought into the reanimation room of our coronary care unit where we were waiting for him. That man looked more dead than alive.

A.A.: Had he during the reanimation opened his eyes now and then, to say something?

T.G.: No, no! Truly, the man was brought in more dead than alive. He even showed post mortem lividity [pale bluish discoloration] and we all had the feeling: what for heaven's sake are we doing here? because the man was ice cold, had been outside in that meadow for no one knows how long, and he looked very bad. He also had no pupillary reflexes whatsoever, which is a clear sign that the supply of oxygen to the head had stopped. During regular checking of the pupils there was no reaction either, and beyond the moments of

checking, his eyelids were closed, so he could not see. He was in such a bad condition that he was unconscious in any case. Thus he was unable to see.

A.A.: He had not given any sign that he wanted to say something?

T.G.: No!

A.A.: Nothing, absolutely nothing?

T.G.: No. After about 15 minutes of reanimation we all were convinced that we were working on a dead man. There was no life in the body. Then one gets the feeling: what am I doing here? This patient is actually dead. But after a very long time, and we were flabbergasted, he did get a little bit of heart rhythm and also a little bit of blood pressure, and he began breathing again, a little bit, that is. But he did breathe on his own! And, at long last, we could send him to the intensive care unit.

Later in the interview, T.G. repeated this part of the story while explaining why he and his colleagues decided to continue reanimation:

T.G.: During that reanimation we often thought: this man is truly dead, so let us stop. But because it was such a young man one continues nonetheless. And then, at a given moment, when one sees just a tiny bit of heart rhythm and one sees that there is an attempt to breathe again, then of course one does continue.... Also the fact that we had a junior doctor with us who did not dare to make a decision in the sense of, "Boys, let's stop – it is done and over with!" made us continue.

A.A.: So all of you thought it was useless to go on with this, but you went on with it anyway?

T.G.: Yes, we often looked at each other, and thus communicated that this made no sense. But we did continue anyway.

Thus, in contrast to Woerlee's conjectures, the statements above clearly indicate that the patient was not "conscious" during the reanimation procedure, at least not during the first 15 minutes or so. He seemed as dead as anyone could be. When medical personnel checked for pupillary reflexes, they found none, and beyond those checks the patient's eyes were closed all the time, up to the end. He also remained unconscious up to the moment that he was moved to the intensive care unit (ICU). Hence Woerlee's statement that "His eyes were partially open, or were opened every now and then to check pupil size as an indication of brain oxygen starvation; so he was able to see his brother [the nurse] and others in the room" (2004, p. 247) has no basis in fact.

*Did the patient feel and hear his dentures being removed and being placed in a drawer?*

Woerlee wrote: “He felt his dentures being removed, and he heard them being placed in a metal drawer; a metal drawer opening and closing makes a very typical sound, and metal bedside cabinets are standard hospital furniture in The Netherlands” (2004, p. 247). This description actually was not the case: Medical personnel removed the dentures at the very beginning of the reanimation procedure, when the patient was truly clinically dead, so he could not have felt that action. The nurse removed them in the reanimation room, but he did not place them in a metal drawer that he subsequently closed. In describing what actually happened, T.G. reported:

T.G.: The man was in his early 40s. He was found in a meadow near the village of Ooy, where he came from, as it appeared afterwards. He was heavily suffering from hypothermia; in hindsight this could have been his salvation, because people who are heavily hypothermic do not use much oxygen, and due to that they may get through very time-consuming reanimation procedures. When the three of us took over the reanimation, he was first put onto a bed. At the time when he had to be intubated so to as to apply artificial respiration, it appeared he still had his dentures in. So I took those dentures out and put them onto the crash cart, that is, a small cart that is always in that reanimation room and onto which all sorts of infusion bottles and medicines are placed. Yes, actually all you need for a reanimation can be found on that crash cart. The reanimation required, in all, more than an hour. In the end, the heart rhythm had returned, also some blood pressure, but respiration was still tiresome, but finally it was decided to send him to the intensive care unit for further artificial respiration.

A.A.: What did the reanimation procedure consist of?

T.G.: A very time-consuming heart massage [not only manually but also using a heart massage machine] as well as five episodes of defibrillation – in all, three quarters of an hour – and, of course, artificial respiration. So finally he began to breathe on his own, but that was not good enough, since his body had been acidified so much, due to lack of oxygen, that he had to go to the intensive care unit for further artificial respiration.

Note that the nurse put the dentures *onto* the cart. He did not put them into a drawer that he first opened and then subsequently closed. Instead, as T.G. described later in the interview, he put the dentures

onto an already extended *sliding shelf* – that is, a flat wooden plate sticking out from the cart – and he left them there, forgotten:

A.A.: This sliding shelf, did you pull it out? Could he have heard that?

T.G.: No, that sliding shelf was already pulled out. We used it for preparing syringes, bottles, that sort of thing. I distinctly remember to have smacked the upper and lower dentures upon that wooden sliding plate only to get rid of them and next continue with the intubation and reanimation. Later on the patient was transferred to the ICU, and apparently during tidying up the mess after the reanimation was done, those dentures got lost somehow. I have not seen them again.

This is important because it counters Woerlee's statement that the patient could have heard the sound of a drawer sliding open and clicking in again. Later in the interview, T.G. revealed another important detail when A.A. asked whether the patient had ever been in the resuscitation room before:

T.G.: This was [his] first ever admittance to the hospital and the resuscitation room. As for that crash cart, it is unique in the entire hospital. Nowhere else in the hospital was such a crash cart available.

After the job was done, T.G.'s night shift was over and he stayed home for five days. When he returned to the hospital he did not see the patient for another few days, so in all he had lost sight of the patient for more than a week – and to his knowledge the patient had never seen *him* at all!

A.A.: So you had lost him out of sight?

T.G.: So I had lost him out of sight. He had been continuously artificially respired in the ICU. I had left my night shift and took my free days afterwards. After those days I came back, but was stationed in another department of the nursing ward, so not in the department where the "fresh" heart infarcts are admitted. Then I went to the revalidation department of that ward and there I saw, oh wonder, B., the patient! And, in hindsight, what had happened was that B. had recovered slowly but surely, and at a certain moment he asked where his dentures had gone! In the ICU nobody knew; they [the dentures] had not come with him after the reanimation had been completed and B. was transferred.

Now, at the beginning of my night shift I came into that department to distribute medicines, and I entered the room where B. lay in his hospital bed. He saw me and then said, in the flash of a moment: "Hey, yes you, you know where my



dentures are!" I looked at B. in exasperation. I was already surprised to see that he looked so well, but was flabbergasted that he recognized me, because the last time I had seen him he was still comatose! And his eyes had not been open, except for the times when I checked his pupillary reflexes [those pupils had given no reaction whatsoever]. I said: "How do you know that?" He said: "You were there when I was brought into the hospital, and you removed my dentures from my mouth and put them upon that cart that was there." And he described the cart exactly as it was: "Yes, there were all sorts of bottles on it, and it did rattle a lot, and there was also a sliding plate upon which you put the dentures."

Apparently, T.G. had to disappoint B., because the dentures could not be found:

A.A.: Those dentures no longer occupied your mind?

T.G.: No, because the patient had been transferred elsewhere, and it happened that during that night my night shift ended. And then you no longer think about such things as dentures. They are so unimportant at the time. So I had forgotten all about them.

T.G. also told A.A. that a closer investigation in the ICU had revealed that B. had apparently had a truly massive heart infarct before he was found, more dead than alive, in the meadow. Therefore it was unthinkable to find him so well recovered. Once again he returned to the fact that B., while clinically dead, had seen the crash cart and in particular the flat sliding shelf: "It was in fact a very inauspicious, ramshackle thing, but he had seen it, and he had also seen the dentures upon it."

During T.G.'s conversation with him, B. described the resuscitation room in detail. It was a very small room. At the right side of the bed was a small niche containing a wash basin, with disinfectants and related things. Next he could also describe where a mirror was. At the left side was the cart containing various equipment. There was also a narrow metal cabinet wherein infusers and infusion pumps were stored. Apparently B. could remember everything perfectly well.

A.A.: (repeating the question): He had never before been there?

T.G.: He described everything in detail and also the persons who, at the time, were working on him.

A.A.: How did he describe them?

T.G.: Their appearance: of a [female] nurse who looked so and so, and to me: "I saw you; you were doing the heart massage on me. And I wanted to tell you all the time: 'Ouch, stop doing this because it hurts so much! I am still here; my heart does not

stand still! I am alive!' But you did not hear me." Yes, those were the things he was telling me, and truly this made my eyes roll out of my head, and my ears flap, because these were exactly the things that had happened! He himself apparently had the feeling that everything was functioning well.

A.A.: Can you tell me how he saw himself? Did he see his own body from a certain vantage point in the room?

T.G.: He described this as seeing his body lying on the bed. He found that very strange. He saw his body from the spot where that steel cabinet was, and that was in the corner of the room. He also said that he was floating above us and saw us being busy with his body. But at the same time he also saw me sitting on top of him, and he also felt that. He had truly felt the pressure on his body and the pain it caused.

A.A.: He felt you sitting upon him?

T.G.: Yes, indeed he felt me sitting upon him. I certainly did that while administering heart massage. But we also made use of a heart massage pump. And that is a machine that causes enormous pain. And that is what he told me. He felt the pain, and did try to tell me that. But I saw no reaction in his body; his eyes were shut and during checking the pupils they did not show any response, let alone any sign of fear.

This is quite remarkable: The patient described an out-of-body experience, floating above and seeing everything happening from a certain corner in the room. But at the same time, despite his being in a deep coma, he felt the physical pain of the heart massage.

A.A.: Did he express his astonishment about what had happened to him?

T.G.: Not at all. It was truly amazing that he told all this so matter-of-factly, so down-to-earth. He certainly was not a woolly thinking person, whose fantasy had run wild.

A.A.: What was his vocation?

T.G.: Steel bender, I believe.

A.A.: Certainly a down-to-earth vocation.

Four weeks after admission to the hospital, B. went home, and T.G. never talked to him again. In hindsight, he regretted very much that he had not tried to maintain contact with B. At the time, the Merkawah Foundation also tried to trace B., but to no avail. Apparently he had moved out of the area.

According to T.G., medical personnel made no mention of this NDE in B.'s medical record; but that is not surprising because in the years when the case of patient B. occurred, personnel never recorded such phenomena. However, T.G. did talk about the case to his colleagues, who were vaguely surprised but shrugged it off, with the apparent

exception of a colleague K.B., who was responsible for bringing the story to the attention of Meijers.

### Recent Follow-Up

Although A.A.'s report was highly detailed and extremely interesting, it did not satisfy me, because there remained a few problems. Although it corroborated the dentures story in *The Lancet* rather well, it also contradicted that story in small but fairly important ways. The *Lancet* article reported that the patient desperately wanted the reanimation team to go on at all cost because he was afraid to die if they stopped the procedure. But in A.A.'s account, the patient made no mention of having felt afraid to die. Rather, he *wanted* the team to stop because he felt that he was alive and physically functioning well and because he wished the physical pain caused by the heart massage machine to cease.

In an attempt to reconcile this contradiction, I consulted Meijers's 1991 article. In it, Meijers cited K.B. as having reported that the patient had been desperately afraid that the team would stop resuscitation. Alas, Meijers told me he cannot locate the original transcript of his interview of K.B., so I'm unable to scrutinize that document for information that might further reconcile the discrepancy regarding the patient's emotions and wishes during the resuscitation.

Further seeking a resolution to this discrepancy, I decided to go back to the source. That process was easier said than done, because the dentures story had appeared for the first time 17 years prior to my investigation. In that first document, the article by Meijers (1991), the author cited K.B., a colleague of T.G., as the source. In the second document, the 1994 interview transcript, T.G. himself was the source. Thus, I searched the Internet and identified many T.G.s but not the one who was B.'s nurse during the resuscitation in question. However, I was able to locate K.B., who was still a nurse at the coronary care unit in a major hospital in the Netherlands. After some difficulty making contact, K.B. told me that he had never had anything to do with the whole event, except for having acted as a messenger between T.G., who had done the resuscitation, and Meijers. However, he was pleased to give me T.G.'s current telephone number.

So at long last, in April 2008, I was able to contact the elusive T.G. for a telephone interview. He was most forthcoming but also mightily surprised that his dentures story had not been forgotten and had been disseminated all over the world. He told me that, as a matter of fact,

over all those years the incident had never slipped away from his mind because it had made such an enormous impression on him; he stated that he could remember it as if it had happened the day before! He unhesitatingly confirmed a number of facts he had already mentioned in A.A.'s interview with him, and he was most anxious to help set the record straight, so as to remove all embellishments and misunderstandings about the dentures anecdote that might have emerged over time, including the conjectures by Woerlee in this *Journal* and allegations by other skeptics that it was nothing more than an urban legend. I arranged for a follow-up interview with T.G. by my collaborator, Titus Rivas, who subsequently had a long talk with T.G. and reported back to me the following facts.

The patient, B., from Ooy near the city of Nijmegen, had indeed been brought in on a cold night, more dead than alive, and had undergone the whole procedure as reported in A.A.'s interview with T.G., who was adamant in stating that B. had not shown any sign whatsoever of being conscious at the time. He was clinically dead, period: no heartbeat, no breathing, no blood pressure, and "cold as ice." The ambulance personnel had tried to carry out some reanimation while driving to the hospital, but without result. Most important, *immediately* after B. entered the hospital, T.G. removed the dentures from B.'s mouth and intubated him before starting up the entire reanimation procedure. Therefore, as T.G. categorically stated, *any "normal" observation by the patient of his dentures being removed from his mouth was simply unthinkable* [my italics].

In addition, the normal observation process could not have been the basis of the patient's detailed description of the crash cart as well as of the entire resuscitation room. Once again, T.G. was adamant in that regard, noting that patient B. had never before been in that hospital, let alone in this resuscitation room, and that this particular crash cart was absolutely unique, being a hand-made product of ramshackle quality that had been stationed in that resuscitation room only and nowhere else. To guess the precise nature of that cart and its contents on the basis of auditory impressions, or through briefly opened eyes characterized by fixed, dilated, unresponsive pupils, was impossible by all accounts. T.G. asserted that certainly it would have been impossible for B. to know precisely where T.G. had placed the dentures.

Rivas also asked T.G. about the fact that the patient experienced *physical* pain while simultaneously looking down from a *nonphysical* location near the ceiling. T.G. stated that at that point in time the

medical team would, indeed, have induced sufficient blood circulation to enable the patient to perceive physical pain. However, T.G. found this aspect of the situation strange, because at that point in the resuscitation procedures, the patient had shown no sign whatsoever of responding to normal sensory stimuli. T.G. surmised that, in all probability, the patient was experiencing normal physical pain sensation. Thus, B. appeared to be reporting information input from two different sources at the same time: from the physical body itself, and from an extrasensory source beyond the body, that is, the out-of-body experience.

As for the discrepancy between the two original documents regarding the way the patient responded to the external heart massage, T.G. said that this discrepancy was only seemingly the case. He described two phases of the reanimation. When patient B. suffered feelings of physical pain caused by the heart massage machine, he wanted the team to stop, because he felt he was alive and well, and thus continuing the painful treatment seemed unnecessary. However, after some time, when the team had been unsuccessful in achieving a sustained resuscitation and considered stopping procedures, patient B. was aware of that development and desperately wanted them to continue. Of course, in both phases the team was not aware of B.'s desires while in his out-of-body status near the ceiling of the room.

According to T.G., B. was a very down-to-earth steel bender who most probably did not even understand that he had had an NDE, including an OBE. Certainly at the time when his medical crisis occurred, the general public in the Netherlands was mostly unaware of near-death phenomena.

T.G. told both me and Rivas that after B.'s discharge from the hospital, T.G. had seen him only once again from a distance when B. came to report to the hospital for a check-up. At that time B. did not look healthy. On the contrary, T.G. said that B. looked like a "cardiac cripple" as a result of his massive heart attack. Indeed, a few years later T.G. saw a death notice in a newspaper stating that a B. from Ooy had died.

As a final comment, with his three decades service as a nurse in the coronary care unit and as a highly experienced paramedical staff member with respectable practical and theoretical knowledge in this field, T.G. is, in my opinion, a highly credible source. I also consider it important to note that, because B. experienced the OBE while clinically dead, his experience was an NDE even though it did not include a tunnel, light, a life review, or other features that other NDErs have sometimes reported.

## Discussion

In many details, this story of veridical perception during an in-hospital NDE, as corroborated by the eyewitness testimony of nurse T.G., does not concur with the accounts given by commentators French (2001) and Woerlee (2004). However, the two authors raised an interesting point regarding the fact that the comatose patient did, at a later stage in the resuscitation process, feel intense pain from the heart massage machine. So it seems that the patient was, indeed, at least to some degree, physically consciousness during the later stages of the process. Nonetheless, the patient's eyes were closed from the time he arrived comatose at the hospital until after his transfer to the ICU except when medical personnel opened them occasionally to check for pupil response and found none, indicating that even then he could not see. Yet the patient described having had an out-of-body experience throughout the resuscitation process during which he had a clear and detailed overview of the resuscitation room. His memory of the room was so complete that, a week later, he recognized nurse T.G., a member of the resuscitation team, and described the room in detail, including the sliding wooden shelf upon which nurse T.G. had laid the patient's dentures.

As for French's (2001) remarks, let us consider them line by line. French wrote: "Unfortunately, they do not report whether any attempt was made to corroborate details with the patient" (p. 2010). Evidently some investigators did make attempts, but they could not find B., probably because he had already died.

French (2001) continued: "On many previous occasions such attempts at corroboration have revealed that the evidence was not as impressive as it initially seemed (Blackmore, 1993)" (p. 2010). That may have been the case for those previous occasions but certainly was not the case regarding this incident.

Finally, French (2001) concluded:

Blackmore (1996) lists several alternative non-paranormal explanations as to why people may sometimes seem to accurately describe events occurring during their NDEs. These include 'information available at the time, prior knowledge, fantasy or dreams, lucky guesses, and information from the remaining senses. Then there is selective memory for correct details, incorporation of details learned between the NDE and giving an account of it, and the tendency to tell a good story.' (p. 2010)

Again, those explanations may be considered in other cases but not in this one: The patient, B., had no information available at the time; he had no prior knowledge of the hospital or the reanimation room; fantasy and dreams would be ruled out by his comatose state and would not explain the accuracy of his perceptions; lucky guesses would be highly unlikely to produce such unusual statements and identifications; selective memory cannot explain the facts of this case; and “tendency to tell a good story” was contradicted by the consistency and lack of embellishment in the interview of A.A. and the follow-up interview many years later, which reflected rather down-to-earth statements of the facts.

In conclusion, the story as related in *The Lancet* corresponds well with the account corroborated here by the eyewitness testimony of nurse T.G. The patient B. appeared to have had an NDE OBE and was not sufficiently aware of the environment he was then in to have perceived by normal means the removal and storing of his dentures. But of course the event happened too long ago to permit corroboration now of all the relevant details, and although the evidence includes the first-hand testimony of an important and reliable witness, it does not include an interview with the patient himself.

The main purpose of this article was to set the record straight as to the facts of this case, while admitting that this case cannot constitute definitive proof of continuation of consciousness, let alone survival of death. But it does provide corroborating testimony that something extraordinary happened at the time, an event that should not be dismissed out of hand as a ridiculous story made up by naïve believers.

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