

English Translation of Transcript of Interview with TG about the “Man with the Dentures”

Foreword by Rivas and Smit

The text that follows consists of an English translation by Gerald Woerlee of an original Dutch article by Titus Rivas, written in 2008 for *Terugkeer*, entitled “Een gesprek met TG over de man met het gebit”

It concerns the well-known Near-Death Experience of the Man with the dentures, described by Pim van Lommel and his co-authors in their important paper for *The Lancet*.

This translation was corrected, improved, and officially authorized by the original author and his colleague Rudolf H. Smit, on behalf of Merkawah/IANDS The Netherlands.

Although parts of this paper had already been translated before by Smit and Rivas for the *Journal of Near-Death Studies*, various scholars and critics of the case the paper describes understandably wished to read the whole text in English.

We hope many remaining questions will be answered by presenting this full text to readers who do not understand Dutch.

Rudolf H. Smit and Titus P.M. Rivas on behalf of
Merkawah Foundation/IANDS The Netherlands

Introduction by the translator

This interview was conducted by Titus Rivas with the male nurse TG during 2008. This transcript was published in an extensive article written by Titus Rivas in the Autumn 2008 edition of the quarterly Merkawah Foundation journal “*Terugkeer*”, volume 19, number 3, pages 12-20, and is copyright of the Merkawah Foundation.

TG, a male nurse is the only living person who had direct contact with the patient concerned in this case, and who spoke with him concerning his experience. The patient concerned died some time after discharge from hospital 1979, making TG the only source of information on this case. However, that does not diminish the value of his testimony in any way.

The interview conducted by Titus Rivas was careful, and corresponded point for point with an earlier interview conducted during 1994.

This translation was made by me, G.M.Woerlee, and checked for accuracy by Rudolf Smit and Titus Rivas.

The original transcript is in Dutch, a language which is not accessible to many people. So this English translation makes the basic facts about this fascinating near-death experience and out-of-body experience available to a wider group of serious students of these phenomena.

The translator decided to place the text in table form with the original Dutch text on the left and the English translation on the right. Each paragraph is numbered, so that serious students can refer to paragraph numbers which makes communication with others easier. **However, the table version is available elsewhere on this site.** – G.M.Woerlee

An Interview with TG on the “Man with the Dentures”*

By Titus Rivas¹

Summary

The author conducted a follow-up of the famous case of the near-death experience of the “Man with the Dentures”. He interviewed the source of this case, A-Level nurse TG, and compared the content of this interview with an earlier interview conducted by Ap Addink during 1994.

Despite some minor discrepancies, the story is consistent with this previous interview. TG provides extensive detail making it clear why the core of the near-death experience of this patient, in particular the correct perceptions of actions that occurred when he had no blood circulation, cannot be explained by current neurological theories. The author concludes the article with an assessment of the reliability and value of the case.

Introduction

On May 1, 2008 I interviewed A-Level nurse TG at his home, as part of a follow-up of the famous case of the “Man with the dentures”. This is a case that appears in the *Lancet* article of the Merkawah team of Pim van Lommel, as well as in his best-seller, *Eindeloo Bewustzijn*. This follow-up was set up and realised by Rudolf H. Smit, Ruud van Wees, Anny Dirven and myself. It is a sequel to an interview by Ap Addink of February 2, 1994, which in turn builds on an earlier document from August 1991 written by one of the co-authors of Van Lommel, Vincent Meijers. The contents of the recent interview was used with permission by Rudolf Smit for an article offered to the *Journal of Near-Death Studies* entitled “The true facts about the dentures anecdote” [this title was changed by the Editor into: *Corroboration of the Dentures Anecdote involving Veridical Perception in a Near-Death Experience*] which was made possible after my interview with TG.

Due to space restrictions I cannot publish the full report of our interview (it fills more than 30 pages A4). The text of the full report, will however soon be on two sites, namely the site of Merkawah and the site of Athanasia. This is a joint project of both foundations.

I will summarize the various parts of the interview below, and give a verbatim account of the most important parts of the interview.

I will then compare the content of this interview with the one conducted by Ap Addink.

Finally, I will consider what we can conclude with regard to this case of the “Man with the Dentures”.



General background

Nurse TG qualified as an A-Level nurse in 1978, subsequently he immediately started training as a CCU [Coronary Care Unit] nurse. Later he also trained in the Intensive Care of the Radboud Hospital and followed a module of recovery care. He currently works at the St. Maartens Clinic in the Intensive Care-recovery room.

TG is not religious, but he believes there is something more “between life and death”. He emphasizes that he is the only one who has had direct contact with the patient in this case. Other versions of

this story are therefore always second or third hand.

TG briefly saw the patient one more time at the outpatient clinic after discharge from hospital, but they did not talk any more about his near-death experience.

The case occurred during the late 70’s, probably late 1979, in the old building of the Canisius Wilhelmina Hospital in Nijmegen. TG remembers that the patient, whose name was Beekhuizen², was around 44 years old and came from Ooij. Unfortunately, there are no medical records available from this period with which we can verify such details. Moreover, Anny Dirven has made telephone contact with many people in the region with the surname Beekhuizen (and some minor variants), but without any result.

Sometime after the last time TG saw the patient, he saw an obituary in the newspaper, from which he concluded that “Beekhuizen” had died.

The nurse remembers the story of “Beekhuizen” so well, because it made an enormous impression upon him. Furthermore, this particular resuscitation was the first he conducted as senior nurse.

The resuscitation

Shortly before “Beekhuizen” arrived at the hospital, TG was informed by the ambulance personnel that: “We are coming with a young man who has had a major infarction, or whatever. We are busy with resuscitation”. The patient was found in a meadow.

TG: He was discovered in a meadow by passers-by, the ambulance found him stone cold and seemingly clinically dead. They saw a young man lying there. They began resuscitation. They brought him to us. The man was brought inside and I saw corpse-like lividity, he looked awful, ash-grey, and no communication was possible. The ambulance personnel continued resuscitation as they brought the man inside, and we took over the resuscitation.

Interviewer: Can you say something about the likely causes of his heart attack?

TG: He was as far as I can remember a hardworking man. Slender built, a tall, slender man. Probably he had a heart at-

* Translated by G.M.Woerlee, and authorized by T. Rivas and R.H. Smit. The original Dutch version was published in “*Terugkeer*” 19(3), Autumn 2008. “*Terugkeer*” (= Return or Coming Back) is the quarterly journal of Merkawah Foundation, an autonomous branch of the International Association of Near-Death Studies (IANDS). At the time Rudolf H. Smit was its Editor.



*The patient was found in a meadow
Reconstruction from "The Day I Died".*

tack during a walk or whatever, and collapsed as a result of an arrhythmia [abnormal heartbeat]. That seems to me most probable cause of the event. I do not know whether he previously had heart problems.

Interviewer: He was picked up by an ambulance. How did that happen?

TG: Most likely the ambulance received a phone call from a passerby. The ambulance drove to Ooij where they found the man with no heartbeat. They started resuscitation because he was so young. They did not know how long he lay there. The bystanders who made the telephone call also did not know how long the man had lain there. Yet they began resuscitation. We waited a long time after receiving the message telling us "We are going to Ooij where someone has been found in a meadow." We readied the treatment room, and all that what was needed for resuscitation.

This was an important evening for me, because it was the first time that I was the senior on duty together with two student nurses. So I felt terribly responsible, thinking; "Something is going to happen and then it all depends on me."

I had the feeling that I had organised everything properly and had thought of all eventualities. We waited a very long time. At last the lift arrived upstairs and the ambulance personnel came inside with the man.

Interviewer: You said the ambulance personnel had already started resuscitation.

TG: What the ambulance did at that time was heart massage and artificial respiration. In the case of artificial respiration performed on the street this is done with mouth-to-mouth respiration. At that time ambulance personnel did not intubate with an endotracheal tube, that was only done in exceptional cases by very experienced nurses. These days they do [endotracheal intubation], in those days they did not.

What they did do was to cover the mouth and nose with a mask and provide artificial respiration with a balloon. You can imagine that this does not work very well in an ambulance, because the paramedic is alone in the back of the ambulance with the patient. He actually has to perform both cardiac massage and artificial respiration. Well that is almost impossible, especially not in a moving car. You can do that perfectly well on someone lying in the hospital, but during the ride from Ooij to Nijmegen you can imagine that artificial respiration and heart massage was very likely insufficient. Certainly, when you find such a young looking person, I can well imagi-

ne that you begin heart massage and artificial respiration, even though you do not know how long the patient has had no circulation.

Interviewer: He appeared very dead

TG: The ambulance personnel applied the electrodes of the defibrillator they had with them, and on the screen they saw ventricular fibrillation. This means that the chambers of the heart were in an uncontrolled, chaotic 'flutter'. There is energy in the heart, but it is uncoordinated, the heart does not pump, and there is no circulation. Its symptoms are exactly the same as of a cardiac arrest. The heart does not pump any more. The only difference is that with a cardiac arrest there is absolutely no more electrical activity. The ECG [electrocardiogram] shows a single stripe, while during ventricular fibrillation there is a lot of electrical activity, but it is chaotic and does not result in any circulation³. So the clinical picture of ventricular fibrillation is the same as that of a cardiac arrest.

They defibrillated him without success on the meadow, that is that you give an electric shock causing all cardiac muscle cells to electrically discharge at one instant, after which they are able to receive stimuli from the sinus node. A person is not definitely dead within the first five to ten minutes after ventricular fibrillation has started. If you successfully defibrillate him within a few minutes, the chances are that the heart just commences beating normally again. Incidentally, the brain can only survive a few minutes without circulation, 5 to 7 minutes, after which there is a high risk of irreversible brain damage.

Interviewer: Can you therefore perhaps conclude from all this that the patient lay in the meadow for at most only a few minutes without a normal heart rhythm?

TG: You might think so, because he eventually got back a heart rhythm in the hospital, began to breathe again, and his blood pressure returned. Another explanation could be that the body of this man lay in the meadow in a very hypothermic state [low body temperature]. If you are very hypothermic, the body uses much less oxygen. Under these circumstances you can survive for much longer with the small amount of oxygen remaining in your body.

The man was brought in as cold as a lump of ice. And it was night in any case, so it would have cooled off anyway. On top of that, he had also lain in wet grass, therefore ...

Interviewer: Now what exactly is the purpose of resuscitation? Is it the actual intention that the patient comes to, that full consciousness returns?

TG: No, the most important thing is that the patient gets a heart rhythm providing circulation and a blood pressure. After a resuscitation, especially when it has taken a long time, people do not immediately regain consciousness because of brain damage due to oxygen deficiency.

You do not say, "Our resuscitation is successful when he opens his eyes." It may be that the resuscitation was successful in terms of recovery of heart rate and blood circulation, but the patient remains comatose for a prolonged period, or for example suffers speech impairment or amnesia as a result of severe brain damage due to oxygen deprivation. I understand the confusion, because now and then in the media the idea is presented that a resuscitated person immediately regains consciousness and gets up. Unfortunately this is not always so.

Interviewer: Okay, so the ambulance team arrived with the patient. What did you do then? How must I visualize the

situation? Can you, if necessary in technical terms, describe what happened?

TG: Yes, the first thing you do is: the ambulance nurse is busy with heart massage and manual respiration using a mask and a balloon. Then you lift the patient into a hospital bed which you can use for resuscitation. This is a special bed with a very hard base. The headboard of the bed is taken out, and one of the nurses stands at the head and takes over the ventilation from the ambulance personnel. The other nurse begins with heart massage, taking over the other function of the ambulance personnel.

At that time we had a heart massage pump in the hospital. Mr. Beekhuizen was also placed under this pump. The advantage of this heart massage pump was that it freed a nurse who could then insert an intravenous line and administer medication. The pump was a device that could administer heart massage combined with respiration. The only thing the nurse at the head of the bed had to do was to make sure that the breathing mask covered the nose and mouth, and perform what is called a “chin lift” to ensure a clear airway. That was all he needed to do. Then the second and third nurses had their hands free to administer medications, carry out doctors’ orders, insert an intravenous line, and that sort of thing.

Interviewer: How many people were present with you?

There were three of us, myself as senior, and two student nurses were present. When we heard that the patient was coming, we immediately called the internist, and I think he was present in the ward a few minutes later. This is the person who takes over the medical aspects of the resuscitation, in the sense that he does not actually do the resuscitation, but instead gives the orders, “Give this medication, give that medication, what have you done already?”, and he also asks the ambulance crew, “How was this man found? What medications have you administered? What is known about this patient?”, etc., that sort of thing.

Interviewer: Did you then immediately ascertain whether the resuscitation had already begun?

TG: Yes, certainly you do. The ambulance staff had defibrillated the man in the meadow, and when he was brought in to us he still had no heartbeat.

Interviewer: He still had none?



*The patient in the resuscitation room.
Reconstruction in documentary “The Day I Died (2003)”*

TG: No, no, no. We immediately connected him to the monitor. That is actually the first thing you do when the patient arrives. You take the patient over and connect him to the monitor. No efficient heart rhythm.

The Dentures

Interviewer: Then we arrive at the moment of the dentures, eh. When exactly did the episode with the dentures occur?

TG: That was at the very beginning. When the patient arrives in the ward he is laid down on a bed. At that moment he is placed under the heart massage pump. I inspected the gentleman’s mouth to insert a “Mayo-tube” [oropharyngeal airway], prior to placing the breathing mask over mouth and nose. When I wanted to insert the Mayo-tube, I saw an upper denture that hung loose in his mouth. I removed it. I was a little surprised that it was still present, because I had expected the ambulance crew would have seen it already. Because they had also performed artificial ventilation and had therefore also performed a mouth inspection before they begun. But they had evidently not seen it. I removed the denture out of his mouth and placed it on a retractable wooden shelf of the “crash car”⁴ we had at the time.

A Mayo-tube is a plastic tube. On the front there is an oval mouthpiece with an oval hole in it and that connects to the lips on the outside. On the inside is a flat, bow-formed oval tube preventing the tongue from falling back into the throat, thus ensuring the airway remains open. That is the only function of the Mayo-tube.

Interviewer: Naturally, the insertion of the Mayo-tube occurred, at least so it seems to me, within a context when there was still no evidence of a heart rhythm?

TG: Yes, there was none at the time. No heart rhythm.

Interviewer: So no blood circulation and therefore also no brain activity.

TG: Yes!

Interviewer: Am I going too fast or is that correct?

TG: No, uh, you could roughly say this. The patient is placed under the pump, the pump starts pumping, it could be that you then get some circulation going. I go to inspect the man’s mouth, I remove the denture, insert the Mayo-tube ...



The (upper) denture is removed from the patient’s mouth. This reconstruction in “The Day I Died” is not correct. The denture was not placed in a tray, but straightaway on a shelf.

Interviewer: Now, of course skeptics will say that the incident with the teeth occurred at a moment that sufficient circulation was restored. Is that possible?

TG: In this case there was no circulation and also no ventilation of the lungs, nor was there any artificial respiration at the time.

Interviewer: But when was sufficient circulation restored in this case? Can you still remember how long that took?

TG: Well at the moment you start heart massage, you can often feel pulsations in an artery in the groin [the femoral artery], and when you feel these pulsations, you assume there is circulation. And that is often a false assumption, because the pulsations you feel in the groin may be pressure waves rather than a true circulation. What do you do to check that? Look at the color of the patient. He was very cyanotic.⁵ When he came in, he had blue lips, and blue nails. You look at the pupils. They were very wide when he arrived, which is a sign of brain oxygen deficiency. When the pupils become smaller or the color of the patient improves, then you can say, "Hey, there is apparently sufficient circulation."

Interviewer: And how did it go in this case?

TG: It took a long time in this case before sufficient circulation returned, and that is why we were busy with him for so long.

Interviewer: And that incident with the denture occurred at the very beginning of all this?

TG: That was at the beginning, upon arrival, after the transfer from the ambulance personnel to us the hospital staff. In the first minute after he arrived in the resuscitation room.

Interviewer: Is it possible, by way of speaking, that he had sufficient circulation two minutes later?

TG: No, no.

Interviewer: So are we truly talking about minutes later? Or half an hour, or ...?

TG: I think in his case half an hour later. At that time during the resuscitation there were also periods in which he had ventricular fibrillation again, which is the chaotic activity of the heart. We then defibrillated him several times again.

Eventually, after more than half an hour of resuscitation, he developed a little bit of heart rhythm. He still did not breathe, so we just continued with artificial respiration. A variety of drugs were administered in the meantime so as to support the circulation and to get the heart rhythm going again.

Eventually he made minimal attempts to breathe. Artificial respiration was stopped for a while, but it became clear that this was not sufficient. So it was ultimately decided to admit the man to the Intensive Care Unit. In the meantime his heart rhythm improved, and he departed for the Intensive Care with a good circulation.

Interviewer: After how long was this?

TG: Somewhat more than an hour.

Interviewer: And you do not know how long it took him to regain consciousness afterwards?

TG: Well, I know that they deliberately kept him asleep in the Intensive Care. He was intubated in the Intensive Care; he received an endotracheal tube. He was purposely kept asleep there. When he woke up there, I do not know.

Interviewer: And they did that, keeping him asleep, because it would otherwise be an unpleasant experience for him?

TG: Intubation is a very unpleasant procedure. But this man was unconscious, and breathed inadequately. The purpose was: to bring him to the Intensive Care for artificial respiration with a ventilator. He lay there for five to six days, but not on a ventilator for the whole time.

Interviewer: But do you have any idea when he finally did regain consciousness?

TG: I think it was one or two days afterwards, but I'm not sure.

Interviewer: No, okay. But in any case not the next day? Do you know for sure?

TG: That's plausible, because it happened at night at the end of the evening. What we do in such cases is ask "What happened to the man to cause him to be found unconscious." Well, eventually you could see from the blood results as well as a full ECG that he had had a myocardial infarction. You can only see it was a large infarction after you have a series of blood tests, and it is unlikely they allowed someone to wake up immediately after having had a large myocardial infarction with a prolonged resuscitation and insufficient respiration.

Nowadays there are very different views on artificial respiration, and it is important to get people from the ventilator as soon as possible. Because ventilators at that time were more primitive than they are now, you had to keep people asleep in order to ventilate them, so it is not very likely that he regained consciousness already after one day and was taken off the ventilator.

The reunion

After about one week after resuscitation Mr. "Beekhuizen" returned to the Cardiology ward. TG saw the patient again while on night shift.

TG: The first thing you do on night shift, after the patient transfer briefing, is to start with the distribution of medicines. And then I came to the room where Mr. Beekhuizen was, I knew he was lying there, because I was to care for him. So I had already gone through his case file, and was surprised that he had returned to us. I had not expected him to survive. That he would die, or stay much longer on the Intensive Care, because while he left us with some heart rhythm and just a little bit of blood pressure, he was basically in a very bad condition.

Interviewer: Yes, but that was after a few days?



*De patiënt is ready for the Intensive Care Unit
Reconstruction in The Day I Died*

TG: That was I think after about one week, much faster than I expected at the time.

And when I opened the door of the room, the man saw me coming in, and I still see that face before me, very surprised and pointing at me “Hey, yes, you, you know where my denture is!” I said: “How come?”, yes, I did say that. “Yes, you were there when I arrived,” he said. I said: “Yes, that is correct.” I said: “But I still don’t know where the denture is, I’ll look for it.” Something like that, and the man said nothing more about the matter. I said: “Yes, I’ll start searching for it straightaway.” I was bewildered, and continued with my round of distributing pills, because of course that had to be done. And in the course of the night shift, I went back to the man and then I said, “Now tell me, how can you know that?” And then his whole story came as I have also described it: “Yes, but ...”

Interviewer: Would you like to tell it again?

TG: The man appeared to tell his story quite matter-of-factly from which I did not get the impression he was very surprised he could talk of these things, but spoke quite soberly as a, I don’t want to belittle him though, as a simple labourer, in his way, that is...

Interviewer: Which he was, of course.

TG: He was a hardworking steel bender and he told me the whys and wherefores. He began to tell me what he saw that he... From a corner of the room he saw me being busy with him, with the heart massage. That he was placed under a device which was hurting him very much so. I can imagine that the compressions from the heart massage pump are more painful than chest compressions administered by a person. It was a pneumatic device that works by using high pressure compressed air to push a rock-hard piston on the chest. He described me taking the denture out of his mouth and placing it on a shelf of a cart with all bottles on it. And he also heard the clattering of the bottles.

Interviewer: Did he also say that he could see this?

TG: He said he saw it. He described that I placed it [the denture] in a drawer. He thought it was a drawer, it was a retractable shelf, but he actually described it as a drawer. I had indeed put his denture there. It lay between various syringes we had prepared for the resuscitation. His denture was on that shelf of the cart as he described. I began enquiring further;



*The patiënt confronts the nurse who had resuscitated him
Reconstruction in “The Day I Died”.*

“Yes, but did you see it?” “Yes, yes, I saw and felt it too, because it was incredibly painful! I wanted to say stop it, because you’re hurting me. I’m alive. Something like that.”

Interviewer: Yes, but did he also say from where he observed all this?

TG: Yes, because it was a very small room. Nowadays it would be absurd to consider using such a small room as a resuscitation room. But it was a small room, and when you look at it from the perspective of a patient lying with his head in the direction of the wall, there was a narrow steel cupboard to the left of the patient. If you saw it now, you would think it was a narrow ramshackle wardrobe, but we used it to store infusion pumps. He described seeing the cupboard from a position above. So he saw himself ...

Interviewer: I presume he didn’t specifically mention the cupboard?

TG: No, but he described it from a high vantage point as he looked down on us from a corner from which he could see the whole room. He also described a small counter in a niche. He could not have seen it while lying in his bed, because it was hidden behind curtains. He lay in the same position all the while, on his back, looking towards the ceiling with closed eyes. I only opened his eyes to check the pupillary reflex. Otherwise his eyes were closed.

Interviewer: I take it that he also couldn’t have seen anything at that moment with his eyes?

TG: The times I looked in his eyes he had very dilated pupils. They were lifeless eyes, eyes that just looked straight up. You raise the eyelid to look at the pupil reflex. That’s what you do. You let go of the eyelid, and it closes again.

Interviewer: I understand that. But those details you mentioned, could he never have observed them in that way?

TG: Certainly not from the angle he described. No, not possible. And he described me very clearly, as well as the two girls present who were my colleagues.

Interviewer: You say: “He described them”, but how detailed was that?

TG: Well, he recognized me immediately. I was continually busy with him. The others too, but as assistants. They were student nurses. They were busy with syringes. They were not performing heart massage at the time. As far as I know, the internist had taken over the artificial respiration, so he stood at the head and gave them orders. He said: “Now do this, now do that.” I was continually busy between the patient and the emergency cart, crash car, drawing up medicines, administering medicines, now and then turning the heart massage pump off to see if the man had a heart rhythm and feel if he had a pulse. He described me clearly. He also described “two girls”.

Interviewer: But nothing else? No hair color or other details?

TG: No, no.

Interviewer: Did he mention any other details?

TG: Um, yes, another important fact was that he had seen and heard our doubts. We had expressed this during the resuscitation; “Yes, what should we do now? We’ve been busy for a long time, still no heart rhythm, and still no blood pressure, shouldn’t we stop?” Yes, and the assistant who was there, was a young assistant internist training to be a full-fledged internist. I think he was afraid to single-handedly assume the responsibility of saying, “Now we stop the resuscitation”.

Interviewer: Wait a moment, the one you called an internist, was actually a ...

TG: That was an assistant internist.

Interviewer: So he did not dare to stop the resuscitation?

TG: No, he did not dare to take the responsibility of stopping the resuscitation. In the meantime the cardiologist had been called and arrived in the hospital after some considerable time. In the meantime we had continued resuscitation. At last, some heart rhythm and pulse returned, and in the meantime the cardiologist had arrived. He asked: "What have you done?" "Yes, we administered this, gave that, so and so." "How long have you been busy?" "How old is this gentleman?" We knew from the ambulance that it was a younger man. You could also see he was not an old man. "Okay, proceed!"

Interviewer: The report of KB tells that the patient, Beekhuizen, was afraid during the resuscitation that they would stop the resuscitation. And your story states that he thought they should stop.

TG: I just stated that he said the heart massage was extremely painful. So Beekhuizen thought something like: "Stop it, because I'm alive, I'm not dead."

Interviewer: Ah, yes, so he really wanted them to stop?

TG: Yes. Later, and then I'm talking about much later during the resuscitation, we asked each other, "Yes, what are we going to do now? Do we stop or do we continue? There is still nothing." And he had heard that. And then he said [in his thoughts - ed]: "Boys, go on, because I'm still here!" At that time he was very afraid that we would stop, that we would let him go.

Interviewer: Ah, so that's how you explain that?

TG: Yes, and the two things he mentioned.

Interviewer: Both?

TG: The heart massage and "saying": "Stop it, because I'm still here!" and later the fear: "Boys, don't stop, because I'm still here!"¹ when he was afraid: "I'm dying."

Interviewer: I get it. Did he mention anything else?

TG: No, he didn't mention anything else. I have heard of other patients who have had a tunnel experience, but not him. He did not describe that at all.

Interviewer: Did he also indicate a beginning and an end of the experience?

TG: No, as I said, he related it in a down-to-earth manner as if what he had undergone was something normal.

Interviewer: But did he not say, for example, that he could see something as he was lying in the meadow?

TG: No. He did not say anything about that.

Interviewer: Probably he also did not really grasp that this is called a near-death experience.

TG: No, a simple hard worker, I can imagine that he had never heard of them [near-death experiences]. And if a man such as he had heard of them, he would have thought: "What nonsense, that doesn't exist! You are dead or alive!"

Interviewer: Is there any possibility that the two female nurses had told him certain things [afterwards], or so? Or that [relevant] information came to him by some other means?

TG: No. At the time when he left our department to go to the Intensive Care, he was still unconscious, and had still not opened his eyes spontaneously. He had heard nothing from my two colleagues. No. Certainly not.

Interviewer: Now it is in itself not very likely that someone would tell him that his denture had been removed, and precisely where it lay, and say further: "Figure it out" or whatever. That is unlikely.

TG: No.

Interviewer: Let's see. Yes, I realize something else: Apparently he had lain for a while without upper denture. How do you explain that no one went looking for it?

TG: In the Intensive Care you always lie without dentures when you are intubated. Prior to inserting an endotracheal tube, one of the conditions is that any dentures are removed. So the man went to the Intensive Care without denture. In the Intensive Care it is unimportant whether a person has his dentures with him or not, and certainly not when he is intubated. A denture is then just ballast. So it is not surprising that no one there looked for it. I can imagine that if this man opened his eyes for the first time after several days, still under the influence of sleep medication administered to him in the Intensive Care, he will probably not ask for his denture in the initial period because he would not be getting anything to eat. If he already received nutrition, it was often administered intravenously, but he would not begin with solid food straightaway.

Interviewer: I see. But how do you explain that he was almost indignant, at least so it seems to me, saying: "You know where my denture is."?

TG: Um, not indignant! No, it was more with certainty, or how should I say, it was a statement of fact. Like: "Ah, here he is! Someone who knows!"

Interviewer: Yes!

TG: I heard that story, too, and it was also documented in the nursing record, "Mr. Beekhuizen has lost his denture."

Interviewer: Yes. But when he said: "You know where that denture is", he said that as something only meant for you personally, or for a nurse who was also present?

TG: No, I entered the room, alone. He lay in a room of six or four, I think, yes. I entered and he said something like "Now he's come, he knows! See?" Sort of, "I told you that denture was somewhere ..." And he said it like "Yes, here he's just come inside, he knows!" That is how I understood it.

Interviewer: Yes, now I want to talk about the that cart or trolley. You called it a crash cart?

TG: Yes, nowadays we would certainly not call it that way, but I think it was a precursor of a crash cart. It was a simple metal cart on wheels with two shelves and a retractable wooden shelf.

Interviewer: Yes, and what actually was its general function?

This cart contained all the drugs, intravenous fluids that you need for resuscitation. This way you have everything close at hand for resuscitation. So you do not go to the medicine cabinet, or have to fetch infusion fluids. It's all there right for the taking.

Interviewer: So it was in general use?

TG: Only in that department. It is not a cart you encountered in the hospital. It was a specific cart made especially for the Coronary Care Unit by the technical department of the hospital.

Interviewer: And there was only one of them?

TG: There was only one of them. It was an existing cart, the same for example as a cart used by the kitchen personnel

to transport crockery, and modified by the technical service. On top of the cart were wooden dividers, and this is where all the bottles, intravenous fluids, and medications were placed. Nowadays crash carts are supplied readymade with a monitor and a defibrillator. Then you are talking about a crash cart professionally constructed specifically for that purpose in hospitals. And this was a very primitive ... home-made product.

Interviewer: But was it a sort of cart that an average patient might recognize at the time, for example because he encountered a similar cart in another department?

TG: No, no, it's like he called it, a 'trolley'. He would not have called it anything else.

Interviewer: Was it not general knowledge in those times, like "well, when you are in the Coronary Care Unit you will find such a crash cart?"²

TG: No, no, certainly not. They weren't there in those days. Instead, we carried a defibrillator and a monitor in our hands. We did not run off with that cart, through the ward or wherever.

Interviewer: So usually patients never saw such a cart, unless they were in that specific room of the CCU?

TG: Yes, but we never ever conducted any guided tour in that room.

Interviewer: Neither was it mentioned in the general brochure of the hospital, like this: "If you happen to be in the CCU, you will see this and that?"

TG: (laughing): No!

Interviewer: With a beautiful picture of the crash cart?

TG: No no! I can say that with certainty. He (patient B) could never ever have seen it anywhere else, also not in the ICU. The thing was built by [the technical staff of] the hospital, for that function alone, in that particular room.

Interviewer: The next question is whether he could have recognized you by your voice. You talked during the resuscitation and ...

TG: That is possible, and I hear it more often when I meet people who were previously patients, that they say, "Hey, I recognize you from your voice. Have you ever worked there or there?" That is correct, that people specifically recognize me by my voice. It is possible in this case that he specifically recognized me by my voice.

Interviewer: But only by your voice?

TG: Yes, I do not know me if he only recognized me by my voice, or the combination of voice and sight. But I do know that people say I do not have an average voice. My voice is hoarse, sometimes people mention to me, even non-patients, "Yes, I remember your voice." Also from former colleagues who I see after ten years say, "Hey, a familiar voice I recognize from the past." I've sometimes heard: "You have the voice of Chriet Titulaer". [a Dutch television presenter of popular science programs during the 70's 80's]

Interviewer: Your voice does sound a bit like that when you hear it for the first time. What did you say when you entered the room of Beekhuizen?

TG: "Good afternoon gentlemen!" At that time men and women were segregated.

Interviewer: By the way he reacted, it sounds rather like he recognized you by sight?

TG: Yes, when I walked in, the door opened to the right, so he did not see me enter initially, because another patient lay

to the left. I looked around the room, and thought: "Oh, there's Mr. Beekhuizen." I saw him lying. And out of that corner, he said yes, that's him. But I had probably already said "Good afternoon gentlemen."

Interviewer: But it appeared earlier that he recognized your face?

TG: Yes, I got that impression very clearly, because he pointed at me and said, "You know where my denture is".

Interviewer: To what extent is the next possibility conceivable? Patient B has seen nothing, but purely based on auditory stimuli, i.e. the noises produced by that crash cart, he has formed a visual image of that cart. What would you think?

TG: Seems very unlikely to me, because on the basis what he said it came across as: "You have seen that cart, period." And how he described the wooden shelf upon which I laid the denture. Due to the noise he could have heard that there was something upon which bottles had been clattering. That could have been the case. But that he was capable of describing a pulled-out flat wooden shelf, upon which I laid the denture. . . That really was something!

Interviewer: That shelf had not been pulled out at that very moment?

TG: No, it was already there because I had laid there the syringes, ready for use. You know, we were informed that a resuscitation was coming along. So we were preparing things. The wooden shelf was pulled out, and I placed the syringes upon it. Hence the description by the anaesthesiologist [Woerlee]: "It was a crash cart with a metal drawer, and one can hear its opening and closing" was wrong. It was not a metal drawer; it was a flat wooden shelf, nothing else. A very simple, flat wooden shelf located underneath the tabletop.

Interviewer: So that anaesthesiologist may have had a modern crash cart in mind?

TG: Yes, as they are nowadays. But this was a very simple, converted metal kitchen cart, made of chromium tubes with two shelves on them, and the upper shelf was divided in square compartments, wherein bottles and ampoules were clattering.

Interviewer: Thus the detail of his [patient B's] description of this "proto crash cart" cannot be explained simply by having heard the sounds?

TG: Certainly not by hearing. He said: "There are all bottles on [that cart] and you are laying the denture upon the shelf." Yes, and he describes this from a position above the metal cupboard—which already indicates that he was able to see, from above, what was on that cart. From the bed it would have been impossible, because there he was in a much lower position and thus could not have seen what was on the cart.

Interviewer: That clatter [of the bottles] he could have heard physically, but that was not sufficient for reconstructing an image of the cart?

TG: Not to reconstruct [an image of] the crash cart. Of course, one could have inferred: "there are bottles," because that one will hear. But you cannot infer from the clatter: "There is a wooden shelf upon which one has laid my denture." Because I could have deposited it elsewhere. But that shelf was the only spot where I could have deposited it with some ease. Otherwise it would have been between the bottles and the ampoules, but of course one would not do such a thing.

Interviewer: But when his denture was removed from his mouth, at that moment he had in any case too little heart rhythm to ...

TG: At that moment he had no rhythm, nothing.

Interviewer: So then it is out of the question that he had enough brain activity at that moment, or residual activity in his senses to have observed everything by hearing.

TG: Yes, it is out of the question. No, at that moment I can be 100% sure of that, no rhythm, no circulation, and I cannot imagine that after all that time that there was enough oxygen in his brain to listen, or see, or to interpret what he observed. No.

Interviewer: This is very important what you are now saying.

TG: Yes.

Pain due to the heart massage pump

Interviewer: Yes, and now I have what I consider a very important question. At one point Beekhuizen told you he experienced severe pain on that bed [during the resuscitation]. I suppose that was at a moment he had no circulation.

TG: That was during the resuscitation. During resuscitation you get some circulation, but that is an artificial circulation. That is the aim of the resuscitation: it is not from out the heart itself, instead you generate a circulation from the outside. That is what you do with cardiac resuscitation: you generate a circulation. And in most cases the circulation only occurs between thorax and head. So only the “small circulation” works. This is also the most important circulation, because if it does not occur, there is a major risk of brain damage. In fact, the only thing that happens is circulation to major organs. The brain is relatively close to the heart and is part of the “small circulation”.

Interviewer: Is it conceivable that this small artificial circulation, as you call it, is in principle sufficient to cause [permit] sensations of pain?

TG: Yes it is. I have experience of the case of another patient who was under the heart massage pump who was even more afraid than Beekhuizen. He even woke up and we quickly turned the pump off, after which he lost consciousness again. Therefore he did not have sufficient circulation himself. It is possible that you resuscitate so efficiently that enough oxygen is transported to the brain that is apparently sufficient for the patient to regain consciousness.

Interviewer: If I couple that back to one of my initial questions, that is, at what point during the whole resuscitation process would you say: Beekhuizen may have had enough circulation, as the skeptical anesthesiologist Gerald Woerlee also asserts, to explain any form of consciousness?

TG: He may have had that after we had been resuscitating for some time. At the moment of removal of the denture from his mouth: at that moment he had no circulation and no heart-beat, so at that moment he could not have seen it.⁶ We had to start the resuscitation at that time. Removal [of the denture] was in preparation for continuation of resuscitation after the patient was transferred to us by the ambulance personnel.

Interviewer: That is clear. And the moment at which he could have felt pain, about how long after removing the denture from his mouth was that? Are we talking about minutes or perhaps a quarter of an hour?

TG: Theoretically, if we look at his pupil reactions throughout the resuscitation, that occurred much later, because his pupils were unreactive as we say, they did not respond to light until much later. They began to react somewhat to light only after more than fifteen minutes after we had begun the resuscitation. Just as his pulse and heart rhythm began later, after about twenty minutes.

Interviewer: But do I understand properly what you are saying: “The pain is actually inexplicable by current standards”?

TG: From what I know, and from what I saw with this man, I cannot explain how he could have felt anything at that moment.

Interviewer: No, okay. By the way did he describe that he could see anything at the same time as he felt pain. Was there a combination ... ?

TG: He saw himself lying under the heart massage pump, and that was incredibly painful. And in between he also saw me busy with him ...

Interviewer: And he felt pain at the same time. So there is some sort of input from two sides, from his physical body, and from a position outside his body.

TG: Yes!

Comparison of the interviews in 1994 and 2008

The first thing you notice when you place the two interviews next to each other, is that the story has hardly changed over 14 years. Bruce Greyson has shown that people usually do not “embellish” their near-death experiences, and that applies in this case to this NDE report by the nurse involved. The story as told by TG has not become more “spectacular” with the passage of years. During 1994 he said that “Beekhuizen” gave a description of the appearance of the two female nurses, but in 2008, this was limited to the recognition that there were two women present. However, in the meantime, TG has been able to reconstruct that the case of “Beekhuizen” should be placed in 1979, and not in 1978.

Another difference is the formulation used by Beekhuizen when he saw TG again. Ap Addink wrote in 1994: – He saw me in a flash and said: “Oh, that brother⁷ knows where my denture is.” While in 2008, TG expressed this event to me as follows: – I still see that face before me, very surprised and pointing at me “Hey, yes, you, you know where my denture is!” and later: – “Well here he comes, he knows! See?”

In 2008, TG posits that he entered the room alone, and if we assume that, it means that “Beekhuizen” could have only used the he-form if he had thought aloud, or had spoken to one of the other patients. It is not a substantive discrepancy, but only a difference in wording, expressing the way “Beekhuizen” immediately addressed TG.

Other differences include a longer description in 1994 of when they thought “Beekhuizen” had died, as well as a more technical technical description of the medical procedures than in 2008. Again, this is no substantive discrepancy, and they arise merely from the questions asked by the interviewers. This applies also for the name “Beekhuizen”, mentioned in both interviews, but in 1994 one answer to a question at the end of the interview is replaced with “Beekhuis”.

Considerations

This follow up interview in 2008 was, as I see it, a confirmation of the 1994 interview. It also removes the apparently contradictory second hand story of the nurse KB. Above all other things, TG's extensive technical descriptions of the resuscitation process clearly demonstrate that the patient certainly had no circulation when his upper denture was removed. Moreover, there is no other plausible explanation possible of what the patient observed at the time.

Generally speaking, TG is not a sensation seeker or publicity-hungry man, but actually a very modest and conscientious person, who values his privacy. He has absolutely no interest or anything to gain by launching an entirely fabricated sensational story. We can therefore (more than usual) rely on the trustworthiness of his story. As Rudolf Smit in his article for the JNDS writes, the skeptics appear to be poorly informed about this case, and use the wrong assumptions.

According to me all this means is that people have correctly attributed considerable value to this case for many years. Until now it is one of the strongest pieces of evidence for the independence of personal consciousness in relation to the physiological activity of the brain. Together with this, it is strong indirect evidence for the theory that consciousness survives the physical death of the brain.

Yet this does not clear up all the questions raised by this case. According to TG the pain felt by the patient as he lay under the heart massage pump was inexplicable. This does not mean that TG was mistaken about the lack of brain activity when the upper denture was removed from the mouth of the patient. We have no reason whatsoever to believe that the central part of the report was based upon faulty assessments by the nurse. The core is stronger than ever.

Notes:

1. With thanks to TG, Anny Dirven, Rudolf H. Smit, Pim van Lommel, Ruud van Wees and Allan Namaki. My dog Moortje kept me company during the interview.

2. Phonetic representation. Moreover, a search by Anny Dirven to the relatives of these patients, so far to no avail.

3. Dr. Pim van Lommel notes in response to this passage: "When one speaks of a "cardiac arrest" in patients with myocardial infarction, more than 95% of these patients experienced ventricular fibrillation, and only very rarely a straight line ECG."

4. Term borrowed from English as a crash cart that you should write, so with one "t" at the end (meaning car trailer in English, while car also means automobile). TG would how- ever, prefer this to be written without a "t" because this is the spelling mainly used [in the Netherlands]. The usual spelling is probably influenced by the Dutch word "kar".

5. He had a blue colour as a result of a lack of breath. Cyanosis is a bluish discoloration of the skin or mucosa.

6. This is confirmed by Pim van Lommel in his answer to a question of Rudolf H. Smit who noted that Woerlee cannot claim there was sufficient circulation of oxygen in the brain to explain the consciousness of the patient.

7. To avoid confusion, it should be noted that in the Netherlands a male nurse is called a "brother", a female nurse is called a "sister"

Postscript:

In late August 2008, we tried to find biographical information about the patient through the Regional Archives Nijmegen and the Central Bureau for Genealogy in The Hague. This search was based on the names: Beekhuizen, Beekhuis, and all possible spelling variants, belonging to a man who lived in Ooij and died before the end of 1994. Unfortunately, no information about this man was found. This certainly does not imply (as skeptics would perhaps hope) that the man never existed, but only that his name was probably different to that remembered by TG.

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Comment on Woerlee by A-Level nurse TG

Foreword

The publication of the interview with nurse TG by Titus Rivas in "Terugkeer" led to a critical rejoinder by Gerald Woerlee, also published in Merkawah's journal "Terugkeer"

One of the persons who responded to Woerlee's critique was TG himself. In order to make his valuable response available to non-Dutch readers, Woerlee offered to write a translation of it, which was checked and authorized by us, Rudolf H. Smit and Titus P.M. Rivas, on behalf of Merkawah.

We hope this translation will enrich the debate about the case of the Man with the Dentures described by TG during the interview that Rivas had with him.

Rudolf H. Smit & Titus P.M. Rivas on behalf of
Merkawah Foundation/IANDS The Netherlands

Introduction by translator

This is an English translation of the commentary published by A-Level nurse TG on an article published by G.M. Woerlee in the Winter 2008 edition of the Merkawah Foundation quarterly journal called "Terugkeer".

Its value is that it contains extra information supplementing the extensive transcript published in the Autumn 2008 edition of "Terugkeer".

This commentary was published on page 8 of this edition of the journal: TG, (2008) Commentaar op Woerlee door A-verpleegkundige TG, *Terugkeer*, volume 19, no. 4, page 8.

This English translation is made by G.M. Woerlee and R. Smit. As with the earlier translation this one is also available (see elsewhere on this site) in table form, with each paragraph numbered and the Dutch juxtaposed with the English so that serious students can check the accuracy of the translation, as well as have a method of referring to each paragraph.

The accuracy of the translation has been checked by R.H. Smit, T. M. Rivas, and myself. – G.M. Woerlee

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Comment on Woerlee by A-Level nurse TG

I have carefully read the article by Dr Woerlee. It is evident that Woerlee has a nuanced approach to the event and has consulted a great deal of literature to explain his version of the event.

The most important fact, namely the removal of the dentures after arrival in the hospital, before the continuation of the resuscitation that had been started by the ambulance personnel, most certainly did not take place at a time that there could have been any form of consciousness.

At arrival [at CCU], Mr. B was transferred from the ambulance and taken over by us, placed upon the resuscitation bed, turned on his side so as to position the heart massage pump [Thumper], and turned on his back again. Next, while standing at the head of the bed, I prepared to install the ventilation mask at which point I saw the dentures and immediately removed them from the mouth of the patient. Only after the mask had been put in place, only then the Thumper was switched on, so only at that moment the resuscitation process was resumed.

At arrival in the [CCU] department [the patient had] wide lightstiff pupils, signs of serious oxygen deprivation in the brain, no heart rhythm capable of maintaining the pump function, but instead ventricular fibrillation. The transport of the patient from the moment of his arrival at the hospital up to the moment of [his] arrival at the [CCU] took more than five minutes. During that period the ambulance nurse could only run beside the gurney; hence resuscitation was hardly possible. It was only tried to maintain some ventilation.

In the old Canisius Hospital the distance between First Aid, where patients arrived, and the CCU was considerable. One even had to take an elevator to the third floor as it was there where the CCU was located. So, much precious time was lost to reach the CCU and next resume the resuscitation procedure. Between the lifting of the patient from the gurney onto the bed, the installation of the heart massage pump, and the factual resumption of the resuscitation, much time was lost, certainly more than a minute. In that period no resuscitation took place and there was definitely no blood circulation.

The dentures — *and I say this with strong emphasis — were removed from the mouth before the heart massage machine was switched on.* So it was impossible that Mr. B would have been conscious and could physically have done the observations of his surroundings as Woerlee alleges he [Mr. B.] had done. Besides, as far as I know nobody has ever been conscious when his pupils did not react to light.

In addition, to me it seems farfetched that during the resuscitation Mr. B would have done observations of his surroundings in the very brief moments that I opened his eyes to check his light-stiff pupils.

The description by Mr. B. from a left upper corner of the resuscitation room can not possibly be a result of vision during my opening of his eyelids to check his pupils, because Mr. B. would have only seen the space above his head. The details he described could only be described if he truly had left his body and had seen himself and the resuscitation team from an entirely different position than from the bed where he lay. Furthermore, when Mr. B. finally got a heart rhythm and was transported to the ICU, he was not "seemingly unconscious" but actually unconscious. The return of a heart rhythm after a very prolonged cardiac resuscitation does not automatically mean that a patient regains consciousness. Depending on the period of oxygen deficiency in the brain, temporary or permanent brain damage may result which only later becomes evident.

I understand that Mr Woerlee, as a physician, wants to explain the whole event on the basis of known research, proven and described situations and research in the past with similar cases. But he possibly ignores the fact that even in 2008 the medical community is still unable to explain and scientifically prove everything, but that does not alter the fact that the event or fact could have taken place. Of course, scientists are primarily focussed on finding evidence for situations that occur. I think that the knowledge of the brain and everything occurring in it, especially during situations of oxygen deficiency

and resuscitation, is still insufficient to explain why exceptional experiences occur with patients.

My report *is what it is*, nothing more or less. I have no explanation for what Mr. B. later told me about what he went through.

It is apparently unacceptable for doctors, and therefore considered untrue, when things happen they cannot explain scientifically. Perhaps this is fortunate, because this means there is always something left to do, to explore, and to research. You have to sometimes accept that not everything in this world can be explained or proven with science.

The most important thing I learned from this event for the rest of my life is that in cases of unconsciousness, coma, sedation (sleep with the aid of medication), anesthesia, is that I always try to take into account that patients may experience, feel, and hear things around him, in spite of what we as professionals may think. And that therefore great caution should be exercised with anything we say or do in with such a patient.

Never assume that a patient who is unconscious/comatose/clinically dead/ anesthetized or sedated, can make no observations in whatever form. Furthermore ... not everything in our lives can be explained or is capable of scientific proof, which is something we sometimes simply have to accept. This fact is something scientists find very difficult to accept.

The most important thing for me is that this does not become a yes/no game with different parties trying to convince each other that they are correct. Merkawah and Doctor Woerlee have each in their own way attempted to investigate the story, and the very fact that many people have done research as a result of this story, is sufficient in my eyes to indicate that I have been taken seriously when bringing this story of a profound event in my life to the attention of the outside world.

TG