The Lived Experience Of Nurses Witnessing End-Of-Life Dreams And Visions Of Dying Patients

THE LIVED EXPERIENCE OF NURSES WITNESSING END-OF-LIFE DREAMS AND VISIONS OF DYING PATIENTS

A Dissertation Presented

by

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ABSTRACT

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Background- End-of-life dreams and visions (ELDV) have been reported for centuries, offering comfort to dying patients, but are underreported, largely due to patients' fear of upsetting people or being judged. This qualitative study aimed to explore the lived experiences of nurses who have witnessed ELDVs and examine the impact of these experiences on their personal and professional lives.

Methods- The study utilized a Three-Interview Series to gather data through asynchronous email interviews focused on nurses early life, spirituality, call to nursing, and how witnessing these events shaped their nursing philosophy about caring for the dying. Husserl's descriptive phenomenology was used as the theoretical framework along with Colaizzi's method of data analysis for determining themes.

Results- Of a total of thirteen who responded initially, six nurses participated, with themes of patients having visions of deceased loved ones, seeing an inner light, and expressing peace and readiness for death. They described feelings of awe, humility, and

privilege and viewed themselves as guides during the dying process, supporting patients and families. Witnessing ELDVs affirmed the nurses' beliefs in the afterlife and influenced their understanding of life, death, and their role in caring for the dying.

Conclusions- We must prepare nurses to support patients and their loved ones during this profound phenomenon and the transitional period from life to death. The nurses emphasized the need for spiritual sensitivity and a holistic approach to end-of-life care. An awareness of spiritual experiences at the end of life can enhance nursing education and practice.

Keywords: *nurse, end-of-life dreams and visions, dying patient, phenomenology, deathbed phenomenon*

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CHAPTER 1

INTRODUCTION

Though "end-of-life dreams and visions" (ELDV) have been reported globally through the centuries, it has only been since the 1990s that scientists took a more serious approach to the findings as actual data vs. just anecdotal. End-of-life dreams and visions are often defined as transpersonal experiences that include and expand beyond the archetypical vision of a "spirit at the end of the bed" (Brayne & Fenwick, 2006; Lawrence & Repede, 2012). The experience often brings people peace, joy, and calmness as they transition into death.

Though the experience may hold a profound meaning for the dying person, research shows that ELDVs are often underreported out of the patient's fear of embarrassment, appearing "crazy," not wanting to frighten their family, and feeling under-supported when it comes to spiritual care from nursing and other healthcare professionals (Brayne & Fenwick, 2006; Moore & Pate, 2013; Nyblom et al., 2022). Nurses have reported a need to support dying patients and their families when ELDVs occur (Fenwick et al., 2010; Santos et al., 2017); the problem is that knowledge of ELDVs is often not taught in nursing school, mentioned in the text, or included in ongoing training of holistic care for the dying (Moore & Pate, 2013). There is also a shortage of research on the reflective experiences of nurses who have witnessed ELDVs and how these experiences have influenced their personal and professional lives. The topic remains taboo and dismissed in many nursing arenas due to the lack of scientific support and religious connotations.

End-of-life dreams and visions are just one of many terms used to identify the end-of-life experiences that occur when terminally ill patients encounter a "spiritual" event in the last months, days, or hours before death and are often hard to explain or define clinically, as no agreed-upon definition exists (Brayne et al., 2006; Hesson et al., 2022). Generally, the term refers to an intense spiritual experience/s that may be a dream or vision that brings a euphoric sense of peace, joy, and readiness for death (Devery et al., 2015; Ethier, 2005).

Other death bed phenomena (DBP) or end-of-life experiences may include terminal lucidity and an overwhelming desire to mend relationships (Kerr et al., 2014; Santos et al., 2017). The shared death experience (SDE) refers to a phenomenon in which an individual who is witnessing an ELDV reports experiencing elements of the dying process alongside the person who is dying (Moody & Perry, 2010). Events are almost entirely reported by mentally sound patients who are aware of their surroundings and can recall the experience with clarity and conviction.

The most common ELDV is of dead relatives providing emotional comfort and collecting the patient to journey to the other side (Santos et al., 2017). Terminal lucidity occurs when the patient, while in the end stage of dementia, suddenly becomes conscious and alert and may wish to spend time with family. Death usually ensues a short time after. Though the research on ELDV is relatively recent, the recorded history of DBP is not unprecedented.

The historical stories of ELDVs are not specific to a culture, creed, or socio-economic group of people but date back to the early onset of recorded ethnography (Badham, 1997). Many medieval sources of DBP were from male and female religious

orders and were typically viewed as miraculous manifestations of God and other heavenly hosts' communication with the world (Kroll & Bachrach, 1982).

There are also documented accounts of children and adolescents experiencing ELDVs, in which they reassured and comforted their parents by expressing that they were going to be “all right,” as noted by Atkinson-Ethier and Rembert (1997). Though scientists, physicians, and nurses have hypothesized the medical explanations of what causes DBP and ELDVs, not everyone agrees that the explanations are plausible, consistent, and comprehensive to the growing accounts being researched.

There is very little biomedical explanation to elucidate the causality of ELDVs (Holden et al., 2009). In an extensive article written by Dr. Ronald Siegel (1980) on 'The Psychology of Life After Death,' he described the concept of life after death and the descriptions of the spirit's posthumous journey as remarkably similar for all cultures. He goes on to say that the experience of dying "involves common elements and themes that are predictable and definable" (pg. 927). He believed that DBPs were hallucinations that arise from common structures of the brain and nervous system and a normal response of the central nervous system, which could be replicated using LSD and other psychotropic drugs (Siegel, 1980).

Kubler-Ross (1999) observed that dying children displayed greater spiritual maturity and likened the process of death to a transformation, similar to how a chrysalis becomes a butterfly, entering a new life. Though the dying process places the human body under tremendous stress and metabolic change, patients experiencing ELDV demonstrate clear and organized thought compared to delirium, which includes a breakdown in attention and awareness (Dam, 2016; Kerr et al., 2014). A palliative care

team in Camden, England, agreed that the ELDVs differed from organic or drug-induced hallucinations (Brayne et al., 2006). A military nurse, Diane Corcoran (1988), noted that ELDVs enormously impacted dying patients, their families, and the medical staff caring for them. Though discussion of ELDVs is not unusual among palliative and long-term care nurses, many find the concept hard to grasp (Nyblom et al., 2022)

Research shows that patients are more comfortable sharing their ELDV experience with nurses rather than with doctors and other medical staff (Devery et al., 2015; Wholihan, 2016). Nurses tend to build stronger relationships with patients compared to other healthcare providers as they are consistently present at the bedside. These frequent encounters open up opportunities to build a relational bond between patients, their families, and nurses that imbues a mutual sense of trust and caring. According to the World Health Organization (WHO, 2020), care for the dying requires early interventions in order to attenuate physical, psychosocial, or existential suffering.

Moore and Pate (2013) believe that because clinical nurses may be the first healthcare professionals to encounter a patient's ELDV, they need to be knowledgeable and give credence to the phenomena. A study in a Canadian nursing home of nurses and nursing assistants revealed that the vast majority agreed that DBP is a "transpersonal experience," comforting to the dying residents and their families, and a "profound spiritual event" that influences the nurses' own beliefs about life after death (Clayton-Oldfield & Richard, 2022).

It appears that the nurses' opinion about ELDVs falls on a continuum from believing it is only a bio-medical event related to delirium and dementia to they are genuine, religious, and spiritual occurrence (Brayne et al., 2006; Fenwick et al., 2007;

Grant et al., 2021; Nyblom et al., 2022; Santos et al. 2017). Nurses also varied in their comfort level when discussing ELDVs with their patients. Some avoid the subject altogether out of fear of upsetting the patient and feeling ill-equipped to discuss the topic (Devery et al., 2015; Lawrence & Repede, 2012). Findings show that nurses are interested in learning about ELDVs, but knowledge and training about the phenomenon are limited (Devery et al., 2015; Moore & Pate, 2013).

Problem Statement

End-of-life dreams and visions are not uncommon among patients approaching death (Dam, 2016). With the publication of Dr Moody's (1977) work on near-death experiences (NDE), which is the experience of people dying and coming back with stories of an afterlife, there had been increasing interest in ELDVs. However, very little research focuses solely on nurses' lived experience with caring for patients discussing or demonstrating an ELDV and how this affects their personal and professional lives.

Purpose Statement

This study aims to explore the lived experiences of nurses who have witnessed end-of-life dreams and visions (ELDVs) in dying patients and how these experiences impact their personal and professional lives. The research seeks to uncover the significance of ELDVs and contribute to ongoing nursing education on end-of-life care. By providing a supportive and safe environment, this study will encourage nurses to share their stories, offering a framework for reflection on the meaning of ELDVs and their influence on their perspective regarding life, death, spirituality, and the care of dying patients.

Significance to Nursing

Witnessing ELDVs is a familiar concept for generations of nurses. As nurses continue to care for the dying, knowing about ELDVs and their meaning may give nurses the confidence to guide and support patients and loved ones about the phenomenon when and if it occurs. This research may also provide a platform for researchers and educators to examine the evidence for themselves and consider the potential philosophical and educational contributions to nursing and patient care.

Definition of Terms

Death-bed phenomenon- (BPH) Visions that comfort the dying, including dead relatives, religious figures, and means of travel (Brayne et al., 2006; Mazzarino-Willett, 2010). The term generally refers to an intense spiritual experience of a dying patient within months, weeks, hours, and minutes before death (Ethier, 2005). It can include episodes of terminal lucidity and a desire to mend broken relationships (Ethier, 2005; Kerr et al., 2014; Santo et al., 2017).

Dying- A gradual ceasing to exist, having reached an advanced stage of decay or disuse. Advancing towards death or an event occurring at the time of death (Merriam-Webster Dictionary, 2023).

End-of-life Dreams and Visions- A significant, subjective experience of a vivid dream and vision that feels real and meaningful to the dying patient (Kerr et al., 2014). Visions and dreams of deceased family, friends, and religious figures are the most prevalent (Devery et al., 2015; Either, 2005; Fenwick & Brayne, 2011; Kerr et al., 2014).

Phenomenology- Detailed and systematic research that attempts to understand the first person's lived experience (Tassone, 2017).

Qualitative Research- How subjects make sense of the world, their experiences in life, and the meaning they attribute to a phenomenon (Pietkiewicz & Smith, 2012).

Religiosity- The quality or state of being religious (Merriam-Webster Dictionary, 2023).

Terminal Lucidity- Reported by physicians since the 19th century, terminal lucidity refers to the unanticipated return to consciousness, mental clarity, or memory by an individual with severe psychiatric or neurological disorders shortly before death (Bursack, 2019; Mendoza, 2018).

Shared Death Experience- According to Dr. Raymond Moody (2024)- "Shared Death Experiences (or SDEs) are incredible events whereby one or more loved ones or caregivers report sharing in a dying person's transition to the initial stages of an afterlife."

Spirituality- A sensitivity or devotion to religious values (Merriam-Webster Dictionary, 2023), a transcendence of all religions, and the relationship between ourselves and something greater and all that is (Kaiser, 2000). Relating to the aspect of a human that is not material that seeks to be in harmony with the universe, that which is infinite, and comes into focus in times of human disparity such as emotional stress, physical and mental illness, loss, bereavement, and death (Murray & Zentner, 1989).

Research Question

This study addresses the main research question: "What is the lived experience of nurses witnessing an end-of-life dream and vision of a dying patient?" Sub-questions include:

1. Tell me something about your *early experiences* with family, religion, and choosing a nursing career.

2. Share a detailed account of witnessing an ELDV experience with a dying patient.

3. How do you interpret the deathbed phenomena, and how has it affected your personal life and professional career?

Summary

End-of-life dreams and visions are a historical and global phenomenon among dying patients regardless of culture, sex, creed, or socioeconomics (Badham, 1997). The ELDV often profoundly impacts dying patients, their families, and healthcare providers. Patients often express or demonstrate joy, peace, and calm after experiencing an ELDV as they continue the dying process.

Families are also comforted by ELDVs of their dying loved ones and find it contributes positively to the grieving process. These dreams and visions at the end of life are believed to be vastly underreported out of patients' fear of not being believed or supported or wishing not to scare their family members (Brayne & Fenwick, 2006). Nurses are also placed in a difficult position to help dying patients and families when ELDVs occur, as the subject is often taboo and dismissed, leaving little room for nursing education about spiritual experiences (Santos et al., 2017; Fenwick et al., 2010). These intense spiritual experiences may also include terminal lucidity and a desire to mend broken relationships (Either, 2005; Kerr et al., 2014; Santo et al., 2017).

Scientists often struggle to elucidate the cause of ELDVs as they are random events that cannot be controlled or reproduced in the lab with the cause often attributed to a biomedical event, and research on the matter as pseudoscience (Holden et al., 2009). However, evidence shows that patients experiencing ELDV demonstrate clear and

organized thought patterns compared to delirium, which includes a breakdown in attention and awareness (APA, 2013).

In recent decades there has been tremendous interest and research on near-death experiences (Moody, 1975). A near-death experience (NDE) is what people witness in the interim of being clinically dead and successfully brought back to life. It is thought that those with NDE often report such detail about their surroundings and activities while clinically dead that these accounts are unlikely to stem from some repressed memories or neurons firing off in the brain (Kerr, 2014).

A Canadian study of nurses and nursing assistants working in long-term care with dying patients also noted that ELDVs appear to be a "profound spiritual event" that influences the nurses' beliefs about life after death (Clayton-Oldfield & Righcard, 2022). The authors report that there is very little research on nurses' introspective work on the meaning of witnessed ELDVs and how it impacts their own personal and professional lives.

While nurses are frequently the first healthcare providers to whom patients entrust their stories of ELDVs and often witness these events, research suggests their beliefs range along a spectrum from viewing them as purely biomedical phenomena to perceiving them as authentic religious and spiritual experiences (Brayne et al., 2006; Fenwick et al., 2007; Grant et al., 2021; Nyblom et al., 2021; Santos et al., 2017). Nurses have a growing interest in the topic of ELDVs but lack opportunities for education or support groups to share their experiences and try to make sense of the event. A qualitative approach to researching nurses who have witnessed or listened to stories about ELDVs

from dying patients may contribute to a deeper meaning of one's personal, professional, and spiritual life.

Chapter 2

REVIEW OF THE LITERATURE

Introduction

The purpose of this study is to explore the lived experience of nurses who have witnessed or heard stories from dying patients about ELDVs. Several academically recognized search engines were used to conduct this literature review, including CINAHL, Google Scholar, PsychINFO, and PubMed. The search terms included end-of-life dreams and visions, deathbed visions, deathbed phenomena, near-death phenomena, nurse or nurses or nursing. Though research on the Deathbed Phenomenon and ELDVs has been increasing since the 1990s, it is difficult to find a large number of research studies from search engines within the last ten years. As a result, no specific delimiting time frame was used to conduct the search, and many of the articles and book chapters were found from the reference list of suggested articles.

Several reoccurring themes are noted from the various articles and are organized as follows: (a) the definition of ELDVs; (b) the prevalence of participants reporting ELDVs; (c) influencing factors of ELDV reporting; (d) the content of the ELDV experiences; (e) a prognostic indicator of nearing death; (f) the interpretation of ELDVs by patients and family members; (g) the interpretation of ELDVs by nurses; and (h) nursing care of patients experiencing ELDVs. The chapter will conclude with a summary of these findings.

Definition of End-of-Life Dreams and Visions

The definition of ELDVs continues to be fluid. As one aspect of DBP, it is often based on the researcher's interpretation of how they define the extraordinary events that occur to dying patients in their last weeks, days, hours, and minutes before death. Several terms refer to ELDVs, including veridical hallucinations, death-related sensory experiences, end-of-life experiences, death-bed visions, end-of-life phenomena, end-of-life experiences, death-bed communications, and transcendence phenomena, to name a few.

The term ELDVs appears popular among several articles and will be used for this research paper along with DBP. The origin of the term “end-of-life dream and vision” is unclear, but death-bed visions were first discussed in the 1886 book *Phantasms of the Living* by Edmund Gurney, Frank Podmore, and Frederic Myers. This body of work discussed seven hundred analyzed cases of supernatural phenomena, including deathbed visions (Moody & Perry, 2011). In 1924, Sir Willam Barrett, a physics professor at the Royal College of Science in Dublin, collected and studied dozens of deathbed experiences and conducted the first scientific study of the deathbed phenomenon of the dying. He concluded that the ELDVs experienced by dying patients were spiritual and supernatural in nature. A book of these studies was published in 1926 titled *Deathbed Vision: The Psychical Experiences of the Dying.* Sir Barrett described the "many remarkable" events of people seeing and recognizing deceased relatives or friends during the dying process (Moody & Perry, 2011).

In later years, the work of Peter Fenwick, Sue Brayne, Chris Farham, and Hilary Lovelace are some of the most referenced authors on the topic of ELDVs following the

early 2000s. Their research on a palliative care team in Camden and the dying process of patients in a Gloucestershire nursing home in England, along with Sir William's work, offers a conceptual foundation upon which others are building their own research. (Brayne et al., 2006; Brayne et al., 2008).

According to Brayne, Farnham, and Fenwick (2006), ELDVs are hard to explain and broader than seeing ghostly visions. The nurses and doctors who participated in a pilot study at a Gloucestershire nursing home and a Camden Palliative Care Team in the United Kingdom agreed that ELDVs occurred relatively often and were deeply spiritual. The visions of dead relatives who are actively involved with the dying patient and work to help them transition from life into death are common (Brayne et al., 2008). Family members also witness, through sight or feelings, phenomena surrounding the dying person, such as light that emits a feeling of love and compassion, vapors, changes in room temperature, clocks stopping, and appearances and disappearances of birds or animals (Brayne et al., 2008).

Comatose patients and patients with advanced dementia become lucid long enough to make peace with family members and say goodbye (Brayne et al., 2008). Some patients also had an overwhelming need to make amends for things they have done wrong in their lives and mend relationships with estranged family members. Dying patients also reported dreams and visions that held deep significance for them. These ELDVs are considered a profound part of the dying process, not only for patients but for their loved ones who are grieving them.

Dr. Raymond Moody's shared death experience (SDE) is similar to NDE, but it occurs in people who are present with the dying but are not dying themselves (Moody &

Perry, 2011). During the SDE, one or more loved ones or caregivers share in the dying person's deathbed visions and transition to the initial stages of the afterlife (Moody & Perry, 2011). This experience is compelling because, unlike NDEs, which scientists explain as the product of a dying brain, the participant is fully alive and cognitively intact.

In the near-death experience (NDE), people who died and came back described entering into what can only be described as a paradise in which they had a reunion with dead relatives, experienced a life review, and discovered the true meaning of life (Moody, 1977). For the neurosurgeon Dr. Eben Alexander (2012), he described his NDE as being more real than anything he had experienced in his life on Earth

Though Brayne, Lovelace, and Fenwick (2008) could not pinpoint in their research a precise time that events occurred for different patients, most events happened within the final days and hours before death. Their research on ELDVs is described as a positive experience for most patients, loved ones, and caregivers, though some negative experiences have also been noted. Common words that describe the ELDVs by the Camden team and nursing home staff included "calming, soothing, greeting, comforting, beautiful, readying, and quieting." (pg. 204). The term "profound love" was noted by several researchers, which may help explain the calmness of patients during their passing (Brayne et al., 2008; Fenwick et al., 2007; Brayne et al., 2006; Osis & Haraldsson, 1977; Kubler Ross, 1971).

With an increasing interest in spiritual awareness among religious communities in the Middle Ages, ELDVs were considered to have a deeper meaning and importance in

the Catholic Church. Early writings of the church included the retelling of stories from the New Testament of the Bible, including the story of the Apostle Stephen in the Book of Acts, who shared a vision of heaven, Jesus, and God while being stoned to death in 36 CE (Acts 7:55,56).

A quantitative study by Dos Santo et al. (2017) of healthcare workers in a multicenter study in Brazil reported that 80% of healthcare professionals believed that ELDVs had spiritual significance and were not a result of biological effects. An interesting finding of the study showed that the religious beliefs of the healthcare workers had no impact on the exposure to ELDVs or how they perceived the experience as a spiritual event of the dying patient. The findings also revealed that the majority of healthcare professionals surveyed believed that ELDVs highly correlated with a "transpersonal experience," a "profound spiritual event" that differed from drug-induced or biomedical hallucinations, and were a great source of spiritual comfort for the dying patient. Just as some researchers and healthcare providers believe that ELDVs are spiritual, others believe that it is most likely a physiological explanation such as a disease process, terminal delirium, figments of the imagination, or confusion from narcotics (Fenwick & Brayne, 2011; Nyblom et al., 2021).

Barbato et al. (2017) conducted a quantitative study to measure palliative care patients' Bispectral Index Score (BIS) during the unconscious phase preceding death. The BIS is most commonly used to measure sedation under anesthetics. The study revealed that 73% of the patients had a 40-50 point spike in BIS at the moment of death, suggesting a state of being wide awake despite the patients being unconscious. Following the spike, the BIS score rapidly dropped to zero at the moment of death (Barbato et al.

2017). Interestingly, despite Barbato et al. (2017) patients receiving an opioid for pain and/or a benzodiazepine, these medications had no effect on the BIS scores. While the phenomenon of a BIS spike at death is not new, researchers have found little explanation for its occurrence. Barbato et al. (2017) concluded that the neurophysiological changes responsible for this BIS spike appear to be unrelated to the dying brain. They further suggest that if future studies consistently replicate these results, the surge in BIS may be evidence of ELDVs (Baker, 2017).

The Prevalence of Participants Reporting End-of-life Dreams and Visions

The prevalence of terminally ill patients having ELDVs is overwhelmingly noted and referenced by researchers in several articles, which included children as well (Brayne et al., 2006; Broadhurst & Harrington, 2015; Dam, 2016; Devery et al., 2015; Either, 2005; Moore & Pate, 2013; Nyblom et al., 2022; Santos et al., 2017). Even among patients who were not told they were dying, ELDVs were being reported (Barrett, 1986).

Several articles noted that the reason for the lack of reporting from patients having these experiences was a fear of 'embarrassment,' 'ridicule,' and not being believed by family, caregivers, and medical staff (Brayne et al., 2006; Broadhurst & Harrington, 2015; Dam, 2016; Devery et al., 2015; Nyblom et al., 2022). In a study by Renz et al. (2018), dying patients experience an inner process of traversing from “ego-based” to “ego-distant,” in which patients become free from the fear of judgment and embrace their experiences with honesty and openness.

The concentration of research on ELDVs, primarily in long-term, palliative, and hospice care settings, suggests that those specific care environments provide greater opportunities for encountering ELDV occurrences among patients (Santos et al., 2017).

A study by Moore & Pate (2013) discussed that patients who have experienced ELDVs felt unsupported by nurses and healthcare professionals in spiritual care. Healthcare providers' lack of education in spiritual transcendence may contribute to patients' reluctance to share their ELDVs (Broadhurst & Harrington, 2015). Though research shows that some nurses wish to discuss their experiences of witnessing ELDVs with co-workers, they fear being labeled as 'strange' and have experienced being ridiculed (Brayne et al., 2008). Lawrence and Repede (2013) also noted in their research that a patient's ELDV experience, even when witnessed, is seldom documented.

A comparison study of Britain, India, and the Republic of Moldova research by Fountain and Kellehear (2012) noted that India and Moldova have higher reported incidents of ELDVs than Britain. The reasons for this discrepancy of cases were thought to be related to being a part of a developed vs. undeveloped nation. The higher use of opioids and polypharmacy by Britain in advanced healthcare of dying patients vs. the under-developed and underfunded healthcare found in India and Moldova suggests that drug use may suppress ELDVs while raising the incidence of other hallucinations. The United Kingdom's (UK) higher rate of secularization was also offered as a reason for underreporting because experiencing ELDVs may indicate 'madness,' 'paranormal' activity, and 'disease progression,' which is not accepted in a developed nation (Kellehear 2012). The UK also places a high cultural value on privacy and a need for patients to protect family members from fears they may be experiencing around the subject of death. While the countries of India and Moldova tend to be highly religious, creating a climate of support and acceptance for dying patients' experience of ELDVs.

A study by Muthumana et al. (2010) in India showed that families caring for dying family members were reluctant to share stories of ELDVs and 'traditional beliefs' with highly educated healthcare workers due to embarrassment. Dam (2016) also showed that dying patients in India showed a positive correlation between symptom burden and ELDVs. As the symptom burden increased, so did the occurrence of ELDVs. Data for Dam's study was not gleaned from spontaneous reporting, but only through questioning, as most patients were reluctant to share with anyone about ELDVs due to fear of ridicule.

Grant et al. (2021) found that patients who were open to new experiences, supported by their families and caregivers, were more likely to report experiencing an ELDV. They go on to say that with openness and acceptance of ELDVs, patients and caregivers found comfort in patients' experiences as a natural part of the dying process. Grant et al. (2021) also suggested that some families may not share the witnessing of ELDVs because of a need to protect the event as sacred, profound, and free of judgment. Renz et al. (2018) also suggested that a closed mind and lack of curiosity about the afterlife may hinder the dying process. Fenwick and Brayne (2011) observed in their research that daughters accounted for half of all the reported cases of ELDVs, while the other half included reports from various individuals, such as other family members, caregivers, and healthcare professionals. They suggested that this is because daughters are better communicators, more spiritually connected to their parents, and more open and sensitive to their parent's experience of ELDVs.

Influence of Sample Characteristics on End-of-life Dreams and Vision Reporting

At a glance, it appears that scholars agree that ELDVs are not influenced by culture, time, sex, religion, spiritual beliefs, geographical location, socio-economics,

profession, and location of death, but that would be a false assumption. (Devery et al., 2015; Fenwick & Brayne, 2011; Fountain & Kellehear, 2012; Muthumana et al., 2010; Nyblom et al., 2022; Santos et al., 2017). Researchers vary in opinion of pre-determined factors contributing to patients having an ELDV experience.

Santos et al. (2017) conducted quantitative research from a survey of Brazilian healthcare professionals working in long-term care facilities, a cancer hospital, and palliative care. They concluded that a healthcare provider's religious or spiritual beliefs, especially in organized religion, along with cultural beliefs, were not associated with the 'perception' of ELDVs. While Muthumana et al. (2010) and Kellehear et al. (2012) research showed that the Indian and Moldovian culture and traditional religious beliefs were a factor for ELDVs. In a religious comparison, Muthumana et al. (2010) noted that Hindus living in India had a higher incidence of ELDVs than their Muslim counterparts. Although they are unable to determine the exact reasons, they suggest that religious teaching and beliefs, particularly folklore, may play a role in contributing to the occurrence of these phenomena (Muthumana et al., 2010).

Research by both Muthumana et al. (2010) and Osis and Haraldsson (1977) showed how the death-bed vision of "Yamadoots," a supernatural figure that collects the souls of the dead to carry them into the next world, varied in different regions of India. Muthumana et al. (2010) had no reports of Yamadoots in the country's southern area, while Osis and Haraldsson (1997) had accounts in the northern region. The southern part of India is more developed and has the highest literacy rate in the country. This difference in ELDV occurrences may be linked to social development and a decline in traditional beliefs.

Nyblom et al. (2022), in a study of a palliative care team in a Nordic country, noted that some professionals felt a connection between faith and ELDVs. Grant et al. (2021) carried out mixed method research of family caregivers whose family members died in hospice care in the United States (US) and found that caregivers made sense of ELDVs through religious and spiritual means. Dr. Morse (1994) noted that organized religion is commonly associated with NDE and ELDVs. For example, Muslims report seeing Allah, Christians report seeing Jesus and angels, and Hindus see the Yamadoots at death.

Ethier's (2005) literature review noted that Indian patients identified more religious figures within their visions, while American patients mainly reported seeing dead people. The same study also pointed out that the apparitions noted in Indian culture were more male, while the apparitions reported by Americans were mostly female. Muthumana et al. (2010) also noted that patients diagnosed with cerebral vascular accident had a lower incidence of visions compared to patients dying of other diagnoses. Fenwick & Brayne's (2011) research in the UK observed that there was no difference in the occurrence of ELDVs by dying patients, whether they died at home or in an institution.

Content of Experience

End-of-life dreams and visions are categorized as events occurring while nearing, just before and after death (Nyblom et al., 2022). Visitations by dead family members or deceased loved ones are the most common vision or dreams (Brayne et al., 2008; Claxton-Oldfield & Richard, 2022; Dam, 2016; Ethier, 2005; Muthumana et al., 2010; Osis & Haraldsson, 1977; Santos et al., 2017). Research in India and Moldova cited the

'mother' as the most common vision, while a study in the UK found that the spouse was usually reported (Fountain, 2001; Kellehear et al., 2012; Muthumana et al., 2010). Family, caregivers, and healthcare workers reported seeing the dying patient call out to their visions, converse with them, smile, and physically point to them and reach for them (Barrett, 1926; Claxton-Oldfield & Richard, 2022; Osis & Haraldsson, 1977).

In Dam's (2016) research in India, a dying patient described their mother, who died of cancer, as "fresh, healthy, and wearing nice clothes" (pg. 133). The presence of dead family members and loved ones often bring a dying patient comfort, peace, and warmth, though some patients reported they felt 'scared' and 'confused' as they knew the family member was dead (Brayne et al., 2006; Dam, 2016; Santos et al., 2017). In a study by Nyblom et al. (2022), a nurse shared the story of a 'grumpy man' who, after seeing a vision of his deceased wife, became a joyful person with the assurance that they would soon reunite. The visitation of deceased family members and loved ones is believed to serve the purpose of escorting the dying toward their next life or realm (Barrett, 1926; Osis & Haraldsson, 1977; Santos et al., 2017).

One theme noted in various research is dying patients' reference to traveling (Kellehear et al., 2012; Muthumana et al., 2010; Nyblom et al., 2022). An eight-year-old child in India had instructed her mother that she was not to “hug: or “hold” her anymore as her grandmother was by her bedside and “that it was time for her to go” (Muthumana et al., 2010. pg.105). Visions of religious figures or heavenly beings, such as angels, were also noted to be present to 'collect' individuals, especially among children (Dos Santo et al., 2017; Komp, 1992; Renz et al., 2018). In some cases, seeing non-earthly beings may not elicit feelings of peace and readiness to die. In Brayne et al. (2008) study, a nurse

witnessed a resident telling a vision of angels at the end of his bed to "bugger off!" and voiced that he was not ready to leave. The research articles do not clarify the dying traveler's destiny, but some patients report otherworldly experiences.

In Komp's (1992) study, a seven-year-old child dying of leukemia sat upright and reported to her mother that she was seeing angels and hearing beautiful singing as she had never heard before. She then lay back down and died. Other visions included seeing beautiful places, colors, and powerful, realistic dreams of being in the presence of deceased relatives (Brayne et al., 2008; Devery et al., 2015; Fenwick & Brayne, 2011; Morita et al., 2016). Renz et al. (2018) found that visions of light and angels were the overarching experience of dying Swiss patients. Various studies also reported patients seeing playing children and pets or animals. In a study by Brayne et al. (2008), a resident in the UK told a care assistant about seeing children running by her window, which comforted the elderly patient. The unusual part of the story was that her room was located on the second floor.

For some patients, ELDVs may provide a premonition of their death. An eight-year-old patient dying of cancer (who was not told that he was dying) informed his parents of a dream in which Jesus pulled up in front of his house with a yellow bus, informing him of his approaching death and inviting him to come aboard. The boy shared that he accepted Jesus' invitation and felt great peace from the dream (Komp, 1992).

Another story is of a five-year-old diagnosed with leukemia who informed his parents, "God is coming in 1999." The parents were astonished that the boy showed more excitement about going to heaven than a Make-a-Wish trip to Florida (Ethier, 2005). In India, a 49-year-old cancer patient had a vision of her dead husband and asked her family

to buy a white cloth and her daughter to keep soap handy. In the Islamic tradition, a white cloth covers the face of a person who has died, and soap is used to wash the body (Muthumana et al., 2010).

It appears that even though the children may not have understood the concept of death, they had a sense that they would be peacefully departing this life to an even better destination. Muthumana et al. (2010) showed that most premonitions reported by patients were in the form of visions. A cancer patient in India who appeared well insisted his family move him to a mat on the floor, a Hindu custom in preparation for death (Muthumana et al., 2010). He died that day.

Nurses are also known to have premonitions of death, even if unfamiliar with the patient. A nurse working in a Gloucestershire nursing home had a strange feeling when she walked into the room to set up for a new admission that the resident would not live long (Brayne et., 2008). As it turned out, the relatively healthy patient died within two weeks. Another example from the Brayne et al. (2008) study was of a daughter in England who woke from a dream that her mother was dying. The daughter arrived at the nursing home by four a.m. and sat with her until she died at seven a.m. (Brayne et al., 2008).

A frequent event associated with DBP and often seen by caregivers and nurses is dying patients choosing their own time of death (Claxton-Oldfield & Richard, 2022). Patients may wait hours or days for family members and loved ones to make it to the bedside before dying. Literature suggests that dying patients muster the strength to provide a last opportunity to be together and say 'goodbye' even if one is in the throes of death. Another phenomenon frequently reported by nurses and caregivers is terminal

lucidity, or the term "premortem surge," which was coined by Schreiber & Bennett (2014) (Brayne et al., 2008; Claxton-Oldfield & Dunnett, 2018). A terminal lucidity or premortem surge describes an event when a comatose patient, or demented patient, becomes awake and alert (Brayne et al., 2008; Claxton-Oldfield & Dunnett, 2018). This temporary period of “stunning clarity” provides an opportunity for dying patients to converse and spend time with loved ones (Claxton-Oldfield & Richard, 2022).

Another phenomenon is dreams and visions of dying patients that motivate them to make peace and atone with others for offenses that they may have caused in their lifetime or resolve issues on their own (Brayne et al., 2008; Claxton-Oldfield & Richard, 2022; Santos et al., 2017). In the Brayne et al. (2008) study of long-term care and palliative care participants, an older woman shared her story of being abused as a child and how the experience colored her whole life, causing her to be bitter and alone. After sharing her story, she was able to pass away with a sense of peace and being 'fine.'

The research shows that ELDV is more complex and extends beyond a dying patient's exclusive experience. Paranormal experiences may also be experienced by loved ones and nurses as well. Examples of these phenomena or paranormal experiences include the scent of a dead person's cologne or perfume, electrical malfunctions such as call lights going off in an empty room, and lights and TVs flickering on a unit prior to a person's death (Claxton-Oldfield & Richard, 2022). Claxton-Oldfield and Richard (2022) reported occurrences such as changes in room temperature and synchronistic events like bells ringing or clocks stopping at the exact moment of death. Similarly, Brane et al. (2008) documented witnesses observing vapors rising from the body, along with mist, shapes, and an overwhelming sense of peace around dying patients.

Additionally, loved ones recounted a sudden awareness of the person's death despite being physically distant or being visited by the dying to say 'goodbye.' An example of this phenomenon is the story of an 11-year-old whose grandmother died and appeared at the end of the bed explaining that she was going away to a beautiful place, they would not see each other for many years, and that she would watch over her always. When her parents tried to tell her about her grandmother's death the next day, the girl shared the story of her visiting the night before (Fenwick & Brayne, 2011).

Prognostic Indicator of Nearing Death

The occurrence of ELDVs is widely regarded as a significant indicator of imminent death (Brayne et al., 2006; Claxton-Oldfield & Richard, 2022; Devery et al., 2015). Some researchers suggest that ELDVs primarily occur minutes before death, while others propose they can happen weeks or even months in advance (Devery et al., 2015; Ethier, 2005; Kerr et al., 2014). Ethier (2005) found that most ELDVs occurred within minutes of death. McGrath (2003) observed that for agnostic individuals, experiencing a 'transcendent vision' signaled that death was imminent. Additionally, Kerr et al. (2014), in a mixed methods study of hospice inpatients, found that changes in dream content and increased frequency were also key indicators of approaching death.

Interpretation of End-of-life Dreams and Visions by the Dying Person and Family

Overwhelmingly, the literature on interpreting ELDVs is basically from the observations of the researcher or professional medical staff witnessing the event. The patients who are experiencing ELDV often speak of or demonstrate feelings of peace, happiness, joy, excitement, and deliverance from the fear of death (Either, 2005; Fenwick et al., 2010; Kerr et al., 2014; Nyblom et al., 2021). Family members and

caregivers also shared similar feelings of peace, joy, spiritual comfort, and acceptance of death when witnessing a deathbed phenomenon (Broadhurst & Harrington, 2016; Grant et al., 2021). Grant et al. (2021) found a high correlation between positive ELDVs and positive grief experiences of family and loved ones. The same can be said of negative ELDVs and a negative grieving process. For some dying people, ELDVs may be frightening or distressing, especially if they are not ready to die or lack an understanding of what an ELDV may mean, which in turn causes family members to feel the same way (Dam, 2016; Devery et al., 2015; Morita et al., 2016).

Some patients described their experience as being transcendental. In a study by Arnold & Lloyd (2014), a patient described seeing "radiance," while another patient shared how everything became "magnified," "simple," "elegant," and "beautiful." Another patient in their study reported,

> *"It's like you're in this envelope of just pure love and contentment. I woke up grateful. I go to bed grateful; I laugh a lot. You know you live in the real world but you don't have to always live in that reality. You can rise above that."* (pg. 295)

In the Renz et al. (2015) study in Eastern Switzerland, dying cancer patients reported seeing God as "a great being," a "brilliant light," and "otherness." Patients said that experiencing God as a father, mother, or shepherd helped them feel warm and protected as they were held and supported. Facing death also helped some patients to develop a new spiritual identity and a different understanding of their illness and body. A quadriplegic patient described his transcendental state as being "beyond time," "space," and "body" (Renz et al., 2015). Other patients described a "pure energy," "color," "light,"

or "spirit" that brought them peace (Renz et al., 2015). It was also noted in Renz et al.'s (2015) study that patients also experienced a vision of drifting through "a region of darkness" and having spiritual struggles.

Interpretation of End-of-Life Dreams and Visions by Nurses.

Studies by Claxton-Oldfield & Richard (2022) and Nyblom et al. (2022) show that most medical staff working in palliative and long-term care have experience with ELDVs at work and within their own family. The nurses who participated in the different studies varied in their opinions about ELDVs. Some nurses believed that it was a transpersonal and profoundly spiritual experience, while others thought it was nothing more than confusion and hallucinations due to drugs along with mental and physical deterioration (Brayne et al., 2006; Claxton-Oldfield & Richard, 2022; Nyblom et al., 2022).

Though most nurses accepted ELDVs as beneficial for the patient, they expressed some fear and difficulty fully grasping what was happening and how to discern between ELDV and hallucinations (Claxton-Oldfield & Richard, 2022; Nyblom et al., 2022). The hallmarks for nurses that an ELDV was occurring or had occurred was a change in the patient's demeanor from fear and restlessness to peace, hope, joy, acceptance of death, and a lucid death (Lawrence & Repede, 2012; Nyblom et al., 2022). Though hospice nurses working across the United States noted that 40% of dying patients died a peaceful death without ELDVs, a nurse noted that overall, patients who did not experience the death-bed phenomenon had higher incidents of pain, anxiety, and spiritual distress (Lawrence & Repede, 2012).

In a phenomenological study by McDonald et al. (2013) involving palliative-care nurses in Northern England, the positive impact of ELDVs on the nurses' personal and professional lives was highlighted. The nurses expressed confidence in their ability to distinguish between ELDVs and confusion. Many regarded the patients' experiences as profound and deserving of respect without judgment (McDonald et al., 2013). Although the nurses relied on their scientific training, they often felt conflicted when confronted with phenomena that defied logical explanations.

One nurse based her decision to reject the medical explanation for an ELDV on how the experience made her feel as the energy around the patient became "electric" (McDonald et al., 2013). For some nurses, the patient's experience affirmed their own spiritual and religious beliefs in the afterlife and provided comfort that people do not die alone and that there is something greater beyond this physical existence (McDonald et al., 2013). Participants in the McDonald et al. (2013) study also experienced internal conflict about sharing ELDV experiences, fearing they might be perceived as evangelizing rather than focusing on the scientific aspects of nursing.

While the nurses in the McDonald et al. (2013) study largely agreed on the importance of discussing ELDVs with patients, it was usually the patients who initiated these conversations. One of the nurses took the opportunity of a patient sharing about seeing a dead loved one to ask questions about the patient's past and this person's role within their life. This shifted the nurse's perspective of the dying person from a patient to a human being, fostering a more person-centered approach to care rather than a task-oriented focus (McDonald et al., 2013).

The patient's response to an ELDV greatly influences the nurse's response to the event. If a patient becomes peaceful and no longer fearful of death, a nurse also finds peace and hope for the patient's afterlife experience as well as their own job satisfaction (McDonald et al., 2013). The nurses who reflected on witnessing an ELDV reported some feelings of fear, while others voiced feelings of "guilt" as they did not feel prepared to comfort patients and provide meaning to what an ELDV meant (McDonald et al., 2013).

Care Related to ELDVs

Researchers have overwhelmingly concluded that nurses are not receiving adequate education or training to deliver culturally competent spiritual care to dying patients, leaving many nurses feeling unprepared for this aspect of care (Brayne et al., 2008; Claxton-Oldfield et al., 2022; Devery et al., 2015; Fenwick & Brayne, 2011; Lawrence & Repede, 2012; McDonald et al., 2013; Moore & Pate, 2013; Nosek et al., 2015; Renz et al., 2015; Santos et al., 2017). The lack of education may inhibit nurses from recognizing when an event is occurring, resulting in missed opportunities for comfort, quality care, and possibly overmedicating (Lawrence & Repede, 2012). The palliative, hospice, and long-term care nurses, who often witness ELDVs, are typically more open to discussing the event with patients and peers (Claxton-Oldfield & Richard, 2022; Nyblom et al., 2022).

Research also indicates that nurses seek more formal training to confidently listen, communicate, and help patients and their loved ones understand the meaning behind transcendent experiences while normalizing these occurrences (Claxton-Oldfield & Richard, 2022; Santos et al., 2017). A study by Moore and Pate (2013) showed that many

nurse educators have experienced ELDVs themselves and support including the topic in the nursing curriculum, as well as allowing students opportunities to work with dying patients experiencing ELDVs. Even so, the knowledge about ELDVs is not typically taught in undergraduate nursing education or mentioned in nursing texts (Moore & Pate, 2013).

Various recommendations have been made that can be applied to nursing research and training to improve care for dying patients experiencing ELDVs. Arnold and Lloyd (2013) researched the language of patients having a transcendent experience. The researchers found that patients struggle to explain their experiences in everyday language. Without a trained ear, a nurse may be unable to identify or overlook an invaluable transitional event that a dying patient may be having. In the Claxton-Oldfield et al. (2022) study on training hospice volunteers, a recommendation of developing a booklet or pamphlet of glossary terms or "dos" or "dont's" was suggested to help volunteers recognize and address ELDVs.

Another suggestion was creating a safe space for nurses within institutions or companies free from ridicule or stigma by peers or management in which they can discuss their experience of caring for a dying patient that had an ELDV and the emotional impact that may have had on their personal and professional lives (Depner et al., 2020). Brayne et al. (2008) suggested focus groups or individual meetings with supervision where nurses may share their experiences, voice concerns, and debrief with other nurses.

Having interdisciplinary meetings may also help staff to normalize the events and promote a positive sense of professionalism around the patient's experience (McDonald et al., 2013). Chaplains may also help to provide a sacred space for nurses to become in

touch with their own inner beliefs, attitudes, feelings of life purpose, and coping mechanisms when working with the dying to enhance regular spiritual practices and promote feelings of physical and emotional well-being (Crane & Ward, 2016; Lipski & White, 2022).

Renz et al. (2015) suggested developing an interpretive and epistemological framework to help organize and define spiritual experiences. McDonald et al. (2013) emphasized the importance of nurses reflecting on their own personal beliefs about spirituality in order to recognize any factors that may prevent them from being open to a dying patient's spiritual experience, such as ELDV. McDonald et al. (2013) also recommended a spiritual eco-map to help nurses explore and define various religious dogma, life events, or inner journeys that helped shape how they define spirituality. Whether agnostic or not, knowing one's personal beliefs and sharing with others different views will help provide a foundation to teach and deliver holistic, spiritual care (McDonald et al., 2013; Moore & Pate, 2013).

Summary

The literature review explores ELDVs, a common, global phenomenon experienced by dying patients. Researchers agree that ELDVs are spiritually significant for patients, families, and caregivers, though many patients and nurses hesitate to report these experiences due to fear of ridicule. End-of-life dreams and visions are often seen as a profound part of the dying process, mostly bringing peace and comfort to dying patients and their families.

Despite their prevalence, formal training for nurses in providing spiritual care related to ELDVs is lacking. Many nurses feel unprepared to address ELDVs, though

they recognize their importance in end-of-life care. Studies highlight the need for education and support to help nurses confidently discuss ELDVs with patients and their families, as well as to normalize these experiences. Recommendations by various researchers include creating safe spaces for discussion, integrating ELDV-related content into nursing curricula, and fostering reflection on personal spirituality among nurses to enhance culturally sensitive care.

In essence, the review calls for a greater focus on spiritual training and the integration of ELDVs into nursing education to improve holistic care for dying patients.

CHAPTER 3

METHODOLOGY

Introduction

The study's main purpose was to explore the nurses' lived experience of witnessing an ELDV of a dying patient. Its second purpose was to explore the nurses' reflections on early childhood, religious or spiritual upbringing, and the call to nursing. Its third purpose was to explore how witnessing an ELDV has impacted their personal life and professional careers.

Research Design

The study lends itself to a qualitative approach as it is a human science research project that focuses on the human experience of nurses who have witnessed an ELDV (Dowling, 2007; van Manen, 1997). Husserl's descriptive phenomenology has been a popular research method among nurses since its first introduction in the 1970s (Thomas, 2005; Zahavi & Martiny, 2019). It is a popular method because of the in-depth studies that revolve around nurses, patients, and nursing students' experiences (Beck, 2013, as cited in Hassan, 2023). As nurses care for the entire being of a patient, phenomenology provides an opportunity for holistic nurse research (Patton, 2020).

Theoretical Framework

Edmund Husserl (1970) defined phenomenology as research that focuses on the individual's inner evidence and what appears in consciousness as the object of scientific study. The purpose of phenomenology research is to identify the essence of a lived experience of a particular life event, which may be universal (Van Manen, 1990 & 2016). The goal of phenomenology is not to explain the world but to find a deeper meaning that

connects people within the world (Bloomberg & Volpe, 2019; Smith et al., 2009; Van Manen, 1990 & 2016). Phenomenological research involves studying the lived experience of a small group of people who actively or passively participated in a life event and identifying patterns and relationships of meaning (Moustakas, 1994). Identifying these meanings may bring new knowledge and understanding, contributing to future research.

Phenomenology has remained popular among nursing researchers since its introduction in the 1970s (Thomas, 2005; Zahavi & Martiny, 2019). In an effort to provide quality care and patient understanding, nurses often use phenomenological research because it values the individual's experience and their whole being (Reiners, 2012). This dissertation utilized Husserl's descriptive phenomenology as its theoretical framework. Colaizzi's method of data analysis was used to provide a rigorous and robust analysis of this descriptive phenomenological nursing research (Vignato et al., 2022).

The value of Husserl's philosophy is that he recognized phenomenology as a "transcendental" science that moved beyond the natural and psychological sciences as it seeks meaning in an experience (Smith, 2013). Though nursing researchers have been criticized for not strictly adhering to Husserl's approach to phenomenology, his philosophical outline provides a framework in which novice researchers may follow and organize their work (Hassan, 2022; Paley, 2017, as cited in Hassan, 2022).

Husserl's focus is consciousness. Husserl believed that as a phenomenon occurs, what appears in our consciousness is reliable (Patton, 2020). His idea of revisiting or studying a phenomenon provided an opportunity for genuine knowledge free from problems caused by "our habits of thoughts and language" (Farina, 2014, pg. 52). With

researching ELDVs, Husserl's philosophy allows participants an opportunity to revisit the phenomenon and trust that their experience was genuine and free of preconceived language or beliefs from others. This approach allows nurses an opportunity for enlightenment, which contributes to better patient care (Patton, 2020).

His *research philosophy* of epistemology supports this study's goal of uncovering how a nurse's experience of witnessing an ELDV brings them new knowledge about life, death, spirituality, and care for the dying. Husserl's primary objective was to question, "What is known as a person?"

Husserl's *transcendental phenomenology* allows the researcher to walk in the shoes of others by transcending the perspective of everyday life and exploring a phenomenon in a more profound, more conscious way (Beyer, 2022). He believed that the object of perception is "transcendent" in itself as it has infinite ways to be perceived (even unexpected). Listening to participants' reflections on the event provides new 'truths' that become known through further observation by the researcher (Beyer, 2022). Husserl's transcendental phenomenology allows endless opportunities for nurse subjects to perceive their own experiences while contributing to empirical knowledge.

Another reason Husserl's phenomenology approach was chosen is its emphasis on "bracketing" for acquiring knowledge. Husserl believed that to achieve new knowledge, a researcher's former knowledge and experience should be bracketed so as not to influence gathered data. As a nurse with 33 years of experience and personal encounters witnessing ELDVs, I believe that bracketing provided the best opportunity to capture the pure essence of the participants' subjective and objective experiences.

Bracketed Experience of Researcher

As a registered nurse, my professional background and personal identity shape the lens through which I approached this study. I was raised as a Christian from a working-class background. I converted to Catholicism in my twenties and entered the religious community of the Sisters of St. Benedict in my early thirties, and left the order eight years later. My work experience included two years of hospice, giving me first-hand experience of working with the dying. I recognize that my professional experience and religious background may influence my perspective of the understanding of the data collected.

From a philosophical point of view, I believe the dying process can be a prolonged physical and psychologically taxing event. As humans, we have the instinct to survive and resist with all our might to lose the host body that has been our companion since conception. My philosophy on death is that while we are dying, we begin releasing our body, and our spirit carries on into the embrace of the creator.

Socrates believed that our body is a prison cell in which we view the world through bars and that when we die, we are released and the soul enters a world of purity, eternity, unchangeableness, and immortality, which is called wisdom (Herman, 2013).

Sample

The sample consisted of licensed nurses in the Western Massachusetts area. Convenience sampling was employed to recruit participants, targeting nurses with direct experience in ELDV. The exclusion criteria ensured that participants were limited to nurses who had personally experienced end-of-life dreams and visions, had provided verbal or written consent, and had submitted a partially or fully completed questionnaire.

Recruiting Study Subjects

The recruitment strategy involved sending recruitment flyers (Appendix A) to three hospitals, two rehab centers, two hospice programs, and one long-term care facility. Additionally, three hospice agency nurse managers were contacted for permission to post recruitment letters to their nursing staff; two accepted, while the third declined due to workload concerns. Recruitment flyers were also posted on two Facebook accounts, including Hospice Nursing, and two LinkedIn accounts.

Questionnaire

After nurses contacted the researcher expressing interest in participating in the study, a short Survey of Demographics was sent to determine their eligibility for the study (Appendix B). The demographic information collected included the participant's licensure at the time of the phenomena and the type of nursing practice they were engaged in during that period. The questionnaire also captured whether the participant personally witnessed the event, whether the patient survived or passed away afterward, and whether the participant felt comfortable openly discussing their experience. The value of gathering demographics is to describe who the participants are and what may be the underlying factors for the individual's perception of the phenomenon (Bloomberg & Volpe, 2019).

Data Collection Method

Data was collected using asynchronous emails over six months, using in-depth interviewing with semi-structured questions. A handwritten copy of all paperwork was accepted for one of the participants who did not have a computer, and the research Q&A was duplicated onto a Word document. An introductory email was sent to all potential

participants, informing them of the purpose of the study and including an Informed Consent form (Appendix C). After the consent form was signed, a follow-up email outlining the three-part interview series was sent.

The value of using asynchronous email interviewing is that it is cost-effective and less time-consuming, provides more accessible access, and is a safe space where participants can be interviewed at their convenience (Ratislavova & Ratislav, 2014). Email interviews can also be quickly uploaded into Atlas.ti, copied and posted to the second reader (Ratislavova & Ratislav, 2014).

The semi-structured interview included three separate sections of open-ended questions to solicit information. As the interviews were conducted, additional questions were added for clarification and to encourage a deeper response to the question. Emails were exchanged between the subject and researcher at least 2-4 times and recorded on a Contact Summary Form (Appendix D). After completing the interviews, copies of the Contact Summary Form were saved as a Word document, identified only by the participants' assigned number. A separate translation code linking each participant's name to their assigned number was securely stored in the researcher's University of Massachusetts Google Drive, ensuring confidentiality.

All references to names, email addresses, and institutions are hidden from the analysis and final report. All collected information and documents are kept private and uploaded onto the researcher's and adviser's password-protected computer accounts. The information is only available for those associated with the study, including the second and third readers. Participants have been informed that the study results will be used by

Sherilyn Herron's dissertation for the UMASS, Amherst College of Nursing, and some of their own words may be published in nursing and health journals.

Interviews

The interviews followed Seidman's model of the *Three-Interview Series.* The value of using Seidman's model is that it contributes to a deeper meaning and understanding of the phenomenon by placing it within the context of the volunteers themselves and the lives of those around them (Seidman, 2006). The following guiding questions were used as prompts:

1**. Interview One: Focused Life History**

a. Tell me something about your *early experiences* with family, friends, community, and previous jobs.

b. Tell me about your early experience with religion or spirituality.

c. How did you decide to choose nursing as a career?

2. **Interview Two: The Details of Experience**

a. Please share a detailed account of your experience of witnessing an end-of-life dream and vision (ELDV), otherwise known as a death-bed phenomenon.

b. What do you remember thinking or feeling at that moment?

c. What was the response of others who were present during the phenomena?

d. Did you seek out a chaplain for spiritual support?

3. **Interview Three: Reflection on the Meaning**

a. Given what you said about your early life experiences and what you have said about being a nurse now, how do you understand the end-of-life dreams and visions (death-bed phenomenon) you witnessed?

b. How has it affected your understanding of life, death, and spirituality?

c. How has the experience shaped your philosophy about nursing, particularly care for the dying?

d. How has the experience affected your relationships with family, friends, co-workers, and especially your own personal life's journey?

e. How do you share with co-workers about the phenomenon and the meaning you have discovered from the experience?

Data Analysis and Synthesis

Each participant was assigned an identifier number, and data collected from the email interview was uploaded into Computer-Assisted Qualitative Data Analysis Software (CAQDAS) along with Colaizzi's eight steps of data analysis. Due to the limited number of participants, data management was conducted manually without using Atlas.ti.

The eight steps of Colaizzi's analysis included: (1) reading all text, (2) extracting significant statements, (3) creating meaning for each significant statement, (4) organizing created meanings into groups of themes, (5) combining results into an exhaustive description of each of the three interviews, (6) framing the exhaustive description into a statement of identification of its essential structures, (7) asking the participants for insight into the validation, (8) any new data was worked into the final product of the research (Vignato et al., 2022, pg. 1118).

The Colaizzi's method used for this descriptive phenomenological study provided rigorous data analysis through the understanding of the interview responses and data saturation. This approach helped with dependability in the data analysis process by clearly outlining the steps in order to meet the objective of the study. Manual coding was done on the initial and ongoing data review.

The principal researcher and the second reader initially reviewed the subjects' responses to questions for coding and themes following Collaizzi's (1978) first four steps. Having two readers helped promote the reliability of data observation (Bloomberg & Volpe, 2019). The principal researcher and first reader met several times to identify codes and themes. The codes were then further refined after rereading the initial content and including new information from clarifying questions sent out.

The principal researcher kept a journal to promote self-awareness of any thoughts or biases on the data (Holloway & Wheeler, 2010). The journal was also used to note any thoughts from the principal researcher while coding. Staying consistent with Collaizzi's steps 5-8, a final summation of all themes was created. A copy of the individual themes was sent to all participants for validation to promote the credibility of the collected data. All the participants who responded agreed with how their work was interpreted and the themes they were placed under. Once the participants' comments were received, coding with the data and emerging themes were reviewed again.

The researcher's journal was also used for bracketing, which is also called phenomenological reduction. According to Husserl, bracketing allows the opportunity to

set aside the question of the validity of a phenomenon's actual existence, create neutrality, and reserve the researcher's prior assumptions about the phenomenon (Beyer, 2022).

Ethical Considerations

The goal of the researcher was to be morally bound in conduct to minimize possible harm to those involved in the study (Bloomberg & Volpe, 2019). An application to the UMASS IRB was approved prior to the research being conducted. Subjects signed a consent document that informed them of their rights, as they have the right to be fully informed about the study and how it was conducted. The consent document also informed them of their right to privacy, how their information will be stored, who will have access to the data, and how it will be used. Participants were reminded that participation was strictly voluntary, and they may quit the study at any time without giving a reason.

Limitation

Small numbers are one issue that would make generalizations from this qualitative study difficult. Although only six participants completed the full interview, this is not unusual in phenomenology. Repeating themes were evident from those who did respond, so saturation was met from this small homogenous group. A more significant number of participants would have been required to achieve greater diversity.

Thirteen had originally responded wanting to be interviewed but were either too busy to complete the initial consent form or decided not to participate. Without a physical presence, visualizing non-verbal cues and using other senses limit the researcher's data collection to just written responses (Ratislavova & Ratislav, 2014). Recruiting and responses to questions may be impeded if participants don’t have adequate internet services to participate in the study or lack computer skills (Ratislavova & Ratislav, 2014).

Summary

This qualitative study explored the essence of nurses' lived experience witnessing a dying patient having an ELDV. Convenience sampling was used to recruit RNs and one LPN from various institutions in Western Massachusetts. The interviews were conducted using online emails and tailoring follow-up questions to the subject's response. Seidman's model of the Three-Interview Series helped develop a comprehensive list of questions asked in the study.

Data was initially analyzed and synthesized using the CAQDAS Atlas-ti. v. 23. and Colaizzi's eight-step method to ensure a rigorous qualitative data analysis. It was later decided not to use Atlas-ti, and all responses were synthesized in a Word document and placed on a shared drive through UMASS Amherst to begin coding. Coding was organized into themes using the cut-and-paste computer function in a Word document. Husserl's bracketing method was incorporated to ensure the data collected is valid, viewed with neutrality, and free of assumptions.

The study's limitations include a small sample size of six completed interviews and two partial. The small sample size, while sufficient for achieving thematic saturation in phenomenological research, limits the diversity of the study.

CHAPTER 4

RESULTS

The chapter represents the results of the study and concludes with a summary. After advertising in local healthcare facilities and online for seven months, a total of six participants completed the interviews, and two provided partial interviews after having 13 subjects initially contact the researcher to participate in the study. Multiple attempts were made to contact the remaining five subjects who showed an initial interest in participation but did not complete the consent form. A saturation point was met based on no new themes or codes emerging, redundancy of data, a deep comprehension of the phenomenon studied, diversity in the study, consistency with previous studies, and a feeling of confidence by the researcher and first reader in the data collected. After looking at the interviews of the six subjects who did complete the interviewer the researcher and first reader decided saturation was reached.

Of the six who completed the surveys and interviews, their nursing positions at the time included a nurse educator, a floor nurse, a critical care nurse, two hospice nurses, and one hospice and floor nurse (Table 1). The two additional stories from nurses who did not complete the interviews were a nurse working as an LPN in long-term care and an RN sharing childhood and adult experiences of dying patients.

Table 1: *Participants' Job Description at Time of Experience and Religious Background*

Participant #	**Job Description**	**Religious Background**
Participant 01	Critical Care RN	Catholic
Participant 02	Medical/Surgical Floor RN	Methodist
Participant 03	Floor Nurse/ Hospice RN	Catholic
Participant 04	Nurse Educator	Catholic
Participant 05	Hospice RN	Born Again Christian

Participant 06	Hospice RN	Catholic
Participant 07	Nurse Recruiter	Unknown
Participant 08	Long-Term Care LPN	Unknown

The data was collected until saturation for this small subset of nurses who mainly resided in Western Massachusetts. The participants completed all open-ended questions that followed Seidman's model of the *Three-Interview Series*. Opportunities were provided for any follow-up questions by the researcher and interviewees.

Themes were formulated by both the first and second readers, discussed and agreed upon during a series of several meetings. It was decided to use partial interviews as separate data sets that may contribute to the picture of the experience of observing spiritual and near-death experiences by nurses. Once themes were established with corresponding quotes, they were shared with interviewees for confirmation.

Themes

Using Seidman's model of the *Three-Interview Series* provided an in-depth look at various stages of the nurse's life. Themes were categorized around the three sets of open ended questions used in the online interviews. Under each category, several themes were identified.

The first series of questions explores the personal history of participants, including early childhood, religious upbringing, and a call to nursing. It highlights the relationship between early life experiences that contribute to the nurse's perception of an ELDV and the care of the dying. The themes identified in the **first** background interview included dysfunctional family vs. happy childhood, church, religious education, spirituality vs. discouragement in organized religion, chosen/called vs. practicality.

The second series of questions explored the ELDV experience and its impact on the dying patient, family members, and especially the participants. The themes in the **second** interview regarding witnessing ELDV included: the dying anticipating a trip, being reassured, physical gesture, seeing an inner light, experiencing premonitions, waiting for loved ones to leave or arrive, spiritual guide, feeling peace and love, near-death visions from a nurse who did not complete full interview.

The third series of questions reflected on the meaning of the experience and how it affected their understanding of life, death, and spirituality. It provided a space for participants to reflect on their nursing philosophy, particularly caring for the dying, and how the experience may have affected personal and professional relationships and one's life's journey. Themes from the **third** interview where nurses described how it affected them included: deeply affected, spiritual support from a chaplain, transition of existence and belief in afterlife/heaven, nurse's role as guide, say what you need to say, nurses needing to be open to the spiritual side of death, and sharing with co-workers about the phenomenon.

The research questions are reviewed below, accompanied by the participants' responses, illustrating the themes that emerged from analyses of the lived experience with dying patients and their family members. The grouping of themes is summarized below in Table 2.

Table 2: *Themes Groupings of Interview Questions.*

Interview Category	Themes
1. Interplay of personal history, spirituality, and a calling to nursing	Dysfunctional family vs. happy childhood Church, religious education, spirituality vs discouragement in organized religion Chosen/called vs. practicality
2. The profound experience of ELDVs on the dying and nurses	Anticipating a trip Inner light Experiencing a premonition Waiting for loved ones to leaver or arrive Spiritual guide Feeling peace and love. Deathbed Visions Deeply Affected Spiritual support from clergy
3. Navigating the intersection of life, death, spirituality, and nursing philosophy	Transition of existence and belief in the afterlife/heaven Nurses' role as guide Nurses need to be open to the spiritual side of death Say what you need to say Sharing with co-workers about the phenomena

Next, individual quotes were used to illustrate themes organized by questions and responses.

1a. Tell me something about your early experiences with family, friends, and community.

Interplay of Personal History, Spirituality, and a Call to Nursing

Dysfunctional Family vs. Happy Childhood

From the six complete interviews, three of the participants described having a difficult childhood with "Much domestic abuse," growing up in "a double alcoholic home," and parents divorcing after the father came home from Vietnam as a "changed man." The other three participants had happier childhood memories, such as having close family relationships, many friends in school, and growing up during an "idyllic time" in the United States. One of the participants who struggled in her childhood believed that her abandonment issues as a child "made me more open to spiritual help and its power to helping others."

1b. Tell me about your experience with religion or spirituality.

Church, Religious Education, Spirituality vs. Discouragement in Organized Religion

Most participants were raised in the Catholic Church and attended CCD, First Communion, and Confirmation. Since the 16th and 17th centuries, Massachusetts has been in the top three states for the Catholic population, mainly due to immigration (WorldAtlas, 2024). One participant grew up very involved in the Methodist church, while another attended several churches, including a "hippie church," Assembly of God, and Baptist. At 12 years old, a participant shared that after her mother shared the gospel with her, she became "born-again." A couple of respondents described feeling discouraged about the Catholic religion, and two left the church. One expressed some skepticism about her religion after her mother, who was dying of cancer, had a visitation from her dead, abusive father.

Other participants described their experience below:

"*Although I attended these classes as a child [First Communion and Confirmation] it was made clear in my household how corrupt the church could be."* (Participant 03)

"As I got older, I didn't feel a connection to organized religion and moved towards a more spiritual practice of connection with the world." (Participant 06)

All six participants have grown up in some form of Christian organized religion or spirituality. For some of the nurses, experiencing an ELDV of dying patients was very affirming of their faith, while for one, she became skeptical of her religion and teachings on heaven and hell as her mother had a disturbing vision of a dead, abusive husband. There may be a correlation between being raised in a religion that stresses spirituality and an openness to deathbed phenomena.

1c. How did you decide to choose nursing as a career?

Chosen/Called vs. Practicality

When describing the choice of nursing as a career, participants described feeling predestined for the work, referring to the profession as "*a true calling,"* that "*nursing chose me*," and that "…*God chose me at an early age and foreknew my life's work."* Several participants described an innate need to help or care for people and being caretakers in their earlier lives. For example:

"Always knew I wanted to help people and became a nurse to do so." (Participant 02)

"I had a desire to help people." (Participant 03)

"As long as I can remember, I wanted to be a teacher or a nurse." (Participant 04)

"Nursing had the right amount of caring…" (Participant 05)

"I want to help others have the assurance of hope in their father in there greatest need, which for many, happens during the dying process." (Participant 05)

"I was a caretaker as a child and wanted to help children." (Participant 05)

"Caregiver for father during high school and later in life." (Participant 01)

Others described nursing in terms of practicality as an:

"Occupation that could support myself and would always be in demand." (Participant 03)

"... enough physical skills to keep me from being bored." (Participant 05)

"... a real job." (Participant 06)

In one of the nurse's experiences, her father discouraged her from being a carpenter and made the choice for her to be a nurse. There appeared to be a correlation between a feeling of being chosen or/and called to nursing, a need to care for others, and the choice of becoming a nurse. The choice of caring for others or being called to care for others may create a space of acceptance of various experiences when providing treatment for the dying.

2a. Please share a detailed account of your experience of witnessing an end-of-life dream and vision (ELDV), otherwise known as a death-bed phenomenon.

2b. What do you remember thinking or feeling at that moment?

2c. What was the response of others who were present during the phenomena?

The Profound Effect of ELDVs on the Dying and Nurses

The answers to the first three questions in Interview Two: The Details of Experience often shared common themes. Although ELDVs are typically unique to the dying patient, common themes emerged from the participant's stories.

Anticipating a Trip

Two of the participants talked about the theme of traveling.

"*One time as a hospice nurse and elderly gentleman mumbled incoherently at the end of life that he could hear the train coming and he was afraid he would miss it. His family and I could hear him talking about the train for days as he rapidly declined."* (Participant 05)

In another story by the hospice nurse:

"*Another time, a man who was near death and who had an old truck in the yard that he drove for most of his life kept saying he needed to go somewhere in his truck…"* (Participant 05)

Another participant, working as a hospice nurse, shared an experience with a woman who was dying:

"The day the patient died, the whole family & I were gathered in the living room. The patient was alert and talking. She suddenly stood up out of the chair and told us she had to go. Her mother asked her where she had to go. The patient said she had to go now. Everyone was a little confused by what the patient said and tried to help her walk. The patient just sat down and took her last breath. We were all shocked by what happened." (Participant 06)

The dying patients all expressed an urgency in the need to travel. Traveling for the dying may indicate that, on some level, they understand that they will soon be passing from their current life into the afterlife.

In the participant's stories, it appeared that patients needed reassurance from family and nurses that it was okay to pass on from this life. In the previous cases of the elderly gentleman waiting for the train and the man needing to go somewhere in his old

truck, they had both been holding onto life with much suffering. Once the family and nurse reassured them that it was okay to go, they both died soon after.

"*…we told him the train had arrived, and he could get on the train now; he was able to die peacefully. "* (Participant 05)

"…this man appeared to be holding onto life and had difficulty peacefully passing on. We discussed that perhaps the man recognized he was about to take a journey and perhaps handing him his keys would allow him to travel where he needed to go. The family placed his familiar truck keys in his hands and told the man he could go for a drive- the man soon peacefully passed away." (Participant 05)

In another case, a nurse working on a hospital floor reassured a dying patient said:

"It's ok if you want to go. Your family will be ok. The patient then let go."(Participant 02)

Inner Light

The theme of 'inner light' emerged from two nurses describing the appearance of dying patients, a dying patient experiencing a vision, and a nurse's early childhood vision of her grandmother. These descriptions include:

"*Her skin was very white and her face glowed."* (Participant 01)

"I swear I saw a faint light in her face and eyes with an expression of such joy and peace." (Participant 03)

While describing a vision of people in her room, a patient described them as "shining." (Participant 05)

Lastly, a nurse, while referring to having a premonition of her dying grandmother as a child, stated*:*

"She came to me with a golden aura." (Participant 07)

The participants' observations of a glowing light or aura around a dying patient may suggest a profound transformation or spiritual occurrence during the dying patient's journey.

Experiencing Premonitions

The theme of premonition appears in three of the interviews. Two of the nurses recounted stories of being visited by their dying grandmothers in their younger years. In one case, the nurse was close to her maternal grandmother and had a dream that she had died. The nurse was away at college during the incident and, on contacting her family, was made aware that her grandmother had collapsed at home due to an aneurysm. The grandmother was taken off life support by the family once the participant had returned home. (Participant 02)

In the second case, the nurse, as a child, was staying at her uncle's home as the grandmother was dying and was woken out of her sleep by her dying grandmother, who spoke to her. She goes on to say:

> *"That morning my uncle received a call, and we were brought back to our home, but I already knew what had happened."* (Participant 07)

A third nurse shared a story about caring for a "thin, fragile lady in her 80s" who had recently suffered a fall, resulting in an L2 fracture. She noted:

> "*This specific morning, she told me she had to eat a big breakfast because she was meeting her sister (who was dead). At 11 am she was brought to therapy where she told everyone she was meeting her sister. She promptly had a massive MI and passed."* (Participant 03)

In both cases of the nurses seeing their dying grandmothers as a vision in their youth, the nurses had both been living in the same homes as their grandmothers, and one expressed great affection for her. At the time of the incidents, the nurses were distant from the grandmothers, and it appears that the grandmothers closed the separation gap. These visions by the grandmother appear to be a maternalistic act of comfort.

In the case of the sisters' meeting, the patient sounded excited to see her deceased sister and anticipated that they would be together that day. The nurse who had a vision of her grandmother at the end of her bed was similar by Dr. Moody as an Shared Death Vision (Moody & Perry, 2023).

Waiting for Loved Ones to Leave or Arrive

A few of the nurse's stories discuss patients waiting for a loved one to arrive or leave before passing away. One of the nurses described this as common among dying patients.

> *"In my experience with patients at the end of life- I often see one of two thingsThey hold on and do not let go (pass away) because they are waiting for a family member to get there, or they wait until everyone leaves the room."*
>
> (Participant 02)

In the case of the nurse witnessing a grandmother waiting for her grandson to arrive, the patient displayed extraordinary strength despite her body failing during the end stage of dying.

> *"I had an older Indian woman who was dying from Kidney cancer. She had always spoken about her wish to see her grandson before he died. He was living in India during this time and arranging travel plans to see his grandmother. She*

was very ill at this time and was actively dying. Her feet were mottling, and her breathing was erratic & we had been unable to obtain a blood pressure, but she would not let go. She continued unresponsive. Her grandson arrived and ran to his grandmother told her how much he loved her. She opened her eyes and looked at him, and within a minute, she was gone." (Participant 06)

In one case, it appears that a nurse's mother, who was dying of cancer, encouraged her daughter to leave her bedside to spare her witnessing her passing.

"My mother was placed on hospice due to her advanced cancer diagnosis. I stayed with my parents during this time to care for my mother. My husband and children would visit on the weekend. On this weekend, my mother told me to go out and have lunch with my family after we all had visited with her that morning. I was gone maybe ½ hour when my sister-in-law called me and said I need to come to the house. We returned to the house and my mother was passing. My mother was surrounded by my dad, my brother and his family and mine." (Participant 07)

It appears from these stories that, in dying patients, there is some conscious control over when the dying process is completed.

Spiritual Guide

Several participants referenced dying patients, seeing who they would describe as 'guides' in preparing the dying patient to pass on. The nurses varied in their suggestions of who the guides may be, such as angels, dead relatives, or a loved one. In the case of the dying woman who felt an urgency to leave immediately and dropped dead, her nurse felt:

"It was so different from what I had usually seen. I felt that she had seen her grandmother (who was dead) and was ready to go with her." (Participant 06)

Another participant had two separate occasions of dying women seeing visions of people floating near the ceiling. One of the women was her dying grandmother. What made the cases interesting was the response by the dying women to the visions and the suggestion by the participant of who the visitors may be.

"Twice I have had women (one was my own grandmother on hospice at home) look up to a corner of the room and smile and then look at me as ask, "who are those people?" I questioned my grandmother about them, but she just smiled with lit-up eyes and looked confused that I could not see the people. The other woman said the people were shining. Neither woman was afraid, just curious and confused that I could not see the same people. I told my grandmother that maybe they were angels-she just laughed. My mother was very excited when this happened to my grandmother as she is a very strong believer- she believes this was a visitation from angels." (Participant 05)

Angels are typically known among Christians as messengers, guides, protectors, and servants of God and his people. Keeping this in mind, it would not be too far-fetched to consider that a professed Christian nurse would deduce that an unforeseen, peaceful vision of a person may be an angel.

When contemplating what the nurses had witnessed, two of them suggested:

"I believe that someone that my patient knows was there to help guide them." (Participant 02)

"The visions of gates being opened/closed or deceased relatives visiting a terminal person are part of the preparation. The relatives are the people that are going to help the patient cross over." (Participant 03)

The participant's experience in CCU also noted the patient's familiarity with the vision.

> *"She looked like she grabbed someone and was hugging them, stating "there you are."* (Participant 01)

Another participant noted that her patient showed evidence of terminal lucidity as she no longer was responsive but stared blankly into the distance before awakening:

> *"This day however the lady suddenly smiled at something in front of her, turned her head*
>
> *to look up and smiled again. As the patient looked up and smiled, the AAA*
>
> [Abdominal Aortic Aneurysm] *let go…"* (Participant 03)

In some of the responses, nurses and loved ones speculated that the dying patient was seeing or speaking to dead family members. In the case of the sister-in-law's finger-tapping, the nurse strongly suspected that the dying woman's mother was there.

> *"She "woke up" a third time and tried to sit up, but when I spoke to her, she didn't seem to hear me and was looking off afar…like she was looking at someone behind me. I actually turned to look at it myself, nothing was there except a blank wall and door on that side of the room. I wouldn't say she was alert but on a different plane of existence maybe?" She picked up her right hand, put it on the overhead table and tapped out a rhythm thing with her fingers…. Her mother and she were both finger tappers…. The had an intricate pattern of tapping that took some time. They did it together all the time, I had experience this when they were*

both alive. Anyway, she tapped out the rhythm, all of it, I asked about her mother, no answer, not sure she even heard me, she peacefully slipped into a coma and died 2.5 hours later." (Participant 04)

In another case, when a dying patient, who was on comfort measures only, was seen several times by the nurse and daughter pointing and talking towards the ceiling, the daughter suggested:

"... I think she is talking to her mother and aunt who has been dead for many years." (Participant 02)

In the last case, a nurse was informed by the patient who the vision actually was.

"I also witnessed another patient who told me she saw her grandmother who had died 5 years earlier. She told me that her grandmother was waiting for her." (Participant 06)

Visions by the dying patients were not always noted as invoking a positive reaction by the dying patients. In the case of the nurse whose mother she suspects of seeing her abusive husband noted:

"There he is, why is he here? I believe she was talking about my father. She was very angry in her speech and became more agitated and aggressive about seeing him." (Participant 01)

The suggestion that, as a person navigates through the unfamiliar territory of traveling from life into death and beyond, there is a guide can be comforting. The welcoming nature of the dying women to the perceived visitors may suggest a level of familiarity and acceptance even though they may not know who they are at face value.

Feeling Peace and Love

For some patients, during the dying process, moments of tranquility appear to be noted by nurses, as well as happiness demonstrated with a smile in spite of the fact that the body is rapidly deteriorating. The nurses noted:

> *"She was not afraid to die and that she welcomed death."* (Participant 01)
>
> *"She was so peaceful at that moment."* (Participant 02)
>
> *"She had a huge smile on her face."* (Participant 03)
>
> *"She truly in her last moments opened her eyes and this look of peace came over her and she took her last breath with all of us there."* (Participant 07)

In this one case, the patient died in peace during prayer with her minister and members of her church community.

> '*As I stood at the end of her bed, this little lady who was so cyanotic, glassy, unfocused eyes and barely breathing, turned her head to look at the minister and smiled at him. She passed smiling at him a moment later."* (Participant 03)

In the case of one daughter who was finding it difficult to accept that her mother was dying, even after the patient died from the release of an abdominal aortic aneurysm (AAA), vomiting copious amounts of blood, the nurse noted:

> *"The daughter was amazed at the look of peace that appeared on her mom's face right before she passed. The daughter was finally able to accept that her mom was at peace."* (Participant 03)

Appearing at peace may be paradoxical to what is expected when one is dying, raising questions about what could make a person happy and tranquil, although they are passing from the only world that they have known their whole life.

One of the participants also described that as her patient was dying, she experienced:

> *"I remember feeling how much love there was in that room. I just felt surrounded by it."* (Participant 06)

The family was so grateful for having such a peaceful transition.

Deathbed Visions

In three of the interviews, participants talked about their patients making physical gestures, such as reaching out for someone or acknowledging their presence. Many of the dying patients appeared to be making eye contact with their visions and, at times, moved their heads as if following them around the room. A cardiac care unit (CCU) nurse remembered:

> *"She looked like she grabbed someone and was hugging them…"* (Participant 01)

In the case of the floor nurse, after the patient was reassured that it was 'ok' to leave:

> *"…She slightly raised her hand like she was reaching out and said something that I did not understand. She then took a breath, closed her eyes, and did not take another breath."* (Participant 02)

In the third case, a nurse educator, while visiting her sister-in-law who was dying of triple-negative metastatic breast cancer, the patient, as if looking through her, put her hand on an overhead table and began tapping out an intricate pattern with her fingers, which she commonly did with her mother when she was alive.

Making gestures while dying suggests that dying patients are physically reaching out to who or what appears to be physically present to them. In two of the cases, the

nurses were not able to see who or what the figures were that they were reaching out to. In the third case, the nurse strongly suspected that it was her mother as she was performing a behavior she and her mother would do together when the latter was alive. After witnessing the finger tapping, the nurse inquired of the dying patient how her mother was doing, sensing that she was now present among them. (Participant 04)

None of the nurses doubted that their patients were truly seeing someone, as the physical gestures resembled the familiar behavior of those interacting with the living.

Near Death Visions from a Nurse Who Did Not Complete Full Interview (Participant 08)

One of the nurses working in long-term care had three patients in close proximity on the unit, and all of them mentioned seeing children around the bed.

> *"See, these kids keep coming into my room at night and jumping up and down on my bed and going through my drawers."*

In this case, the patient died unexpectedly during that night, which gave the nurse pause when another patient, who was located across the hall, also reported to the nurse:

> "*Well these kids keep coming in my room at night. They giggle, and go through my drawers, and jump up and down on my bed, I can't get any sleep."*

This patient also passed unexpectedly shortly after. A third resident soon after also reported seeing children that he described as "up to no good." Despite being in hospice care, this patient did not pass away until several months later.

Although the nurse and family may find it perplexing to witness a vision, they cannot see themselves, the patients embrace these visions as very real and often respond to them emotionally and physically.

Deeply Affected

For nurses and others who witness an ELDV in dying patients, the experience often feels profound and evokes a strong visceral reaction. In one of the interviews with the nurse working in CCU, while she and the Cardiologist held the hand of a dying patient who experienced a positive ELDV, they both held each other and cried after she died. Similar to Moody's shared death concept (2024), they both felt that they had witnessed something very profound. The nurse felt that it had changed something in her, and the thought that she may have encountered Jesus or St. Mary caused a visceral response of shivering and crying.

The Cardiologist, who professed he was not religious, also believed that he had witnessed something "…*very amazing and powerful."* The nurse went on to say that the Cardiologist was also crying and happy that the patient was "*pain free and peaceful."* As noted by the nurse working in CCU, other nurses felt witnessing an ELDV was also affirming their faith and the belief in an afterlife. (Participant 01)

> *"I remember feeling at peace for her, being in aww, feeling comforted by the possibility of an afterlife with God and not being alone having passed family guide us."* (Participant 02)
>
> *"Amazement, feeling of being humbled and reassurance there is something more after this life. What an incredible gift to be allowed to witness such a private moment. There aren't words to describe the feelings. Privileged, humbled...I can't really say."*
>
> (Participant 03)

Other nurses shared their thoughts and emotions about witnessing a dying patient experiencing an ELDV, as well as the feeling within the room.

"I was always mesmerized but didn't want to scare the patient…. I was happy to have witnessed it- I was never afraid." (Participant 05)

"I remember feeling how much love there was in the room. I just felt surrounded by it." (Participant 06)

Two of the nurses also described the family's reaction to witnessing an ELDV of loved ones.

"*Shock usually."* (Participant 01)

"Family were mostly amazed and thought it was a beautiful part of their loved one's dying process once I explained that this could happen." (Participant 05)

Though the experience of witnessing an ELDV does not strictly follow the definition of Dr. Moody's (2011) SDE, the inexplicable visions of guides, inner light, and a feeling of peace and love surrounding the dying patient suggests the nurse is witnessing the intersection of life and the afterlife of dying patients. A witnessed deathbed phenomenon is when an observer of the dying patient experiences the deathbed phenomenon themselves, eliciting a profound and, at times, visceral response. During a witnessed deathbed phenomenon, the observer may sense the presence of a spiritual being, or become aware of it through the behavior of the dying patient. The observers may also feel enveloped by an extraordinary feeling of peace and love surrounding the patient as they pass.

2d. Did you find spiritual support from a chaplain, rabbi, or priest?

Spiritual Support from Clergy

When participants were asked if they had received or sought out support from a chaplain, the overwhelming response was that they had not. One of the nurses noted:

> *"I did not feel I needed support. I thought the experience was beautiful."* (Participant 02)

Another nurse expressed that she did not always feel supported by clergy on matters of the afterlife.

> *"Unfortunately, I've learned that having "the collar", certificate or license doesn't make the person a "believer" in Heaven, God or spirituality."* (Participant 03)

In one of the hospice nurses' experiences, a chaplain was a member of the healthcare team and attended meetings with the nurses, providing an opportunity for spiritual guidance when necessary.

3a. Given what you said about your early life experiences and what you have said about being a nurse now, how do you understand the end-of-life dreams and visions (death-bed phenomenon) you witnessed?

Navigating the Intersection of Life, Death, Spirituality, and Nursing Philosophy

Transition of Existence and Belief in the Afterlife/Heaven

For many of the participants trying to explain death, they described a transition of existence. The patient's reality changes from a living, physical being on earth to a spiritual being in death. A few participants described the dichotomy of a person being both physical and spiritual. They also describe a space within the dying process when the physical and spiritual worlds intersect as patients cross over.

" I feel my religious background of Catholic, my switch over to protestant in my teens, and my nursing experience has all led me to believe that there is a spiritual world, other world, Heaven, what you would like to call it. It may be felt more than seen perhaps, and people have a spirit side to them, a soul, whatever you want to call that. I feel when life is slipping away, you come closer to the other "world" and experience things others are not involved in except as spectators." (Participant 05)

"I believe there is a connection with those that are passing within the physical world and the afterlife." (Participant 02)

"The spirit, body, and mind prepare for the next chapter. No fear, no pain, just a family reunion. Guidance if you will. The gate is open when the person is ready to cross over." (Participant 03)

"The deathbed phenomenon has been explained as due to physiological changes in the body as a person is near death. But I feel there is more to these experiences than that." (Participant 06)

One of the nurses described the transitioning phase as "God's waiting room" as the dying patient has "one foot in the world and one beyond." Another nurse believed that after a person dies, a part of them still remains with us.

"The people who have passed before me are always there- in the wind, the sun, the rain- leaving signs and surprises along the way. We need to open ourselves to the moments." (Participant 06)

Several participants, on reflection of ELDVs, believed in the concept of a heaven and an afterlife beyond this physical life. Many expressed a belief that living will

continue somewhere else, that we are guided to that destination, and that it will be a positive experience. Witnessing an ELDV reinforced many of the participants' beliefs in the afterlife. One of the nurses referred to heaven as "the next great adventure."

> *"Death is the end of one book but not the story. The story continues with the next great adventure."* (Participant 03)
>
> *"It confirmed my belief- that death is an appointment, that we are not alone, that others are there to help usher us toward death in a way that speaks to the person on an individual level."* (Participant 05)
>
> *"I do not always understand why a death occurs but try to think there is a higher level of understanding and try and take comfort in believing there is something else good beyond this life."* (Participant 02)
>
> *"I absolutely believe that patients are welcomed to heaven by families, God, Jesus and St. Mary."* (Participant 01)
>
> *"The visions people have of family member of people having the tenacity to hold on long enough for that one person to arrive gives me hope that there is an afterlife."* (Participant 06)

One theme that was noted was the belief that there is an opportunity for spiritual reconciliation, where a dying person may accept an opportunity for spiritual connectedness with a higher power, or in this case, God. One of the participants spoke about dying as a time in which God becomes present to the dying and healing takes place.

> *"That the human mind can commune with God and perhaps be more attuned to God at the end. That God will use any means to reach those He has chosen, even*

death. It is never too late to choose God. The thief on the cross chose in his last hours and he was told he would instantly be in the presence of God."

"It has given me hope that my loved ones who might not be saved could be in the end through a visitation from God or angels. It has made me less anxious and calmer when thinking about the death of my loved ones and my own." (Participant 05)

3b. How has it affected your understanding of life, death and spirituality?

3c. How has the experience shaped your philosophy about nursing, particularly care for the dying?

Nurses' Role as Guide

Participants who experienced ELDVs spoke about the range of reactions to death by dying patients and family members and the importance of being a guide for dying patients, their families, co-workers, and society. The role of a guide may include dialogue, being present to the dying, or promoting the idea of discussion within the community. For one nurse, it was being a member of a hospice team that influenced the way in which one died.

"Death can be painful and scary but it doesn't have to be. With hospice there is hope of comfort and peace. Quality of life even." (Participant 03)

Supporting the patient and family during the dying process and being present at death is part of the nurse's holistic care for the dying.

"I have witnessed many, many deaths and have been by the bedside with most of them. I guess, most of my death experiences, I have witnessed very angry bitter patients. They blame their family for them dying. I witnessed two very different

phenomena from absolutely beautiful to scary and shocking. I believe it is a nurse's responsibility to help guide the patient and the family in the death experience and passing. I always placed someone in the room to be with a dying patient." (Participant 01)

"Death can be scary for people. My experience and personal understanding of life-death experiences is a comfort. Every death is unique to the person. Some people may be terrified, others are accepting." (Participant 06)

"Nurses have the ability to make it a 'good death' for patients and families by providing support and comfort holistically. Being present at the end of a life can be as rewarding as being present for the birth of a life." (Participant 02)

"My philosophy of nursing is closely tied to my faith: that all people are children of God and need to be treated with care, patience, respect, dignity, love and understanding." (Participant 04)

Nurses felt a responsibility to educate patients and families about the dying process and explain ELDVs when they occur. The quotes from these nurses affirm this idea.

"*I feel privileged to have seen this and to have been a part of explaining my understanding of it to family members. The explanation has always brought peace and acceptance."* (Participant 05)

"We need to meet people where they are. Having discussions about death are difficult but so necessary. Involving the family and preparing them for the road ahead is so important. It is such a difficult time in people's lives and to better understand what will or might happen alleviates fear and gives some amount of

comfort to everyone. Being able to provide a peaceful and comfortable space in which to share and listen and guide a person and their family through the process is valuable." (Participant 06)

Participants noted that helping the dying and loved ones understand what may happen or is happening will help alleviate fear and provide comfort.

Nurses Need to be Open to the Spiritual Side of Death

Two participants strongly expressed that nurses, family members, friends, and co-workers need to be open to spiritual events and deathbed phenomenon when they occur. From past experiences with ELDVs, nurses may feel a need to protect the patient and the phenomena as they unfold.

"…all nurses, regardless of their personal bias and belief need to recognize that something spiritual and physical happens to the dying that is beyond just the end of life and to be open to explore this with the patient at the level they chose to explore. There are too many sacred moments and opportunities to serve people during the dying process- our nurses need to have compassion, empathy, and try to understand these concepts and embrace them, even if they do not understand them, for the sake of the patient and family." (Participant 05)

"If a family member, friend or coworker starts to make comments about nothing being there after this life, I firmly encourage them to be more open and tolerant. And not to say such things within hearing of a terminal patient." (Participant 03)

One of the participants expressed that it was important to her not to "push" her beliefs about an afterlife upon her dying patients. Conversation would only be initiated in cases where patients are frightened by a deathbed phenomenon.

"…I don't push my belief of "something on the other side" to my dying patients. If they ask, I will share and reassure them but they need to initiate the conversation. The only times I've started the conversation is when I can see the terror in my patient's face and they can't ask the question themselves." (Participant 03)

Another participant said that even if she doesn't understand what may be happening with a patient experiencing an ELDV, her job is not to "judge" but to "support."

"I believe this experience has taught me that there are things I don't understand but they may be meaningful to my patients and it's not my job to judge, assume or decide, but to support any patient in their time of need, with what they need." (Participant 04)

Having an openness to ELDVs supports the patient's experience, dispels fear, and fosters an environment of empathy and compassion. Though some participants were open about their beliefs concerning ELDVs, one participant felt it was important not to impose her beliefs on patients but to openly share when dying patients and loved ones have questions or fears related to an event.

3d. How has the experience affected your relationships with family, friends, and co-workers?

Say What You Need to Say

One participant, when responding to the questions, expressed that her experience with ELDVs had not impacted her relationships with family, friends, or co-workers in any way.

"*Frankly, most of them are not interested and do not care."* (Participant 01)

Another participant felt sharing her experience was helpful for all. Being of a certain stature in the nursing profession, sharing her experience not only brought validity to them but, in turn, supported nurses who were questioning their own experience. Two other participants also reflected on how it helped them think about their own death and their wishes prior to dying.

> "*It has made me able to make my own wishes about how I want to die known to my son. To be able to speak freely about death makes it less frightening in a way…. When you can talk about death you can make your wishes known and it gives one a feeling of some control over what is to come."* (Participant 06)

When reflecting by a participant on the death of her sister-in-law, the nurse voiced some regret that she did not take the opportunity to speak with her when she had the chance.

> *"I've come to learn to say the things I need to say to everyone before it is too late. [Sister-in-law's name] was private, and I didn't pry too much, but in a way, I feel my relationship to her was sister and friend but perhaps a bit of mothering as well. There are so many things I still want to talk with her about. I don't want that to happen to me with others. Perhaps others need to know as well."* (Participant 04)

Experiences with ELDVs affected participants' relationships with others by influencing nurses to communicate more openly about their own death, ensuring their wishes are known, and learning to say important things to loved ones before it is too late.

3e. How do you share with co-workers about the phenomenon?

Sharing with Co-Workers About the Phenomenon.

There were mixed responses when participants discussed sharing their experience of ELDVs with co-workers. One of the participants felt that due to work-load, there wasn't time to share experiences.

> *"Nurses really just do not have time to share their experiences because it is so busy and other patients are waiting to be admitted to the unit."* (Participant 01)

This nurse eventually shared with the Ethics Committee, but was discouraged by the results of her sharing.

> *"I was on the Ethics Committee at [hospital name] and I was able to talk about my experience with the team and with people who really cared. I think a lot of people are just not interest in hearing about it or just do not believe in it. The Ethics Committee wanted to put on a "grand round" about death and dying but it never happened. I guess it was just not important enough."* (Participant 01)

Participants wrote that they felt comfortable sharing with co-workers, but were more likely to share with like-minded colleagues. One participant had encountered a nurse(s) who dismissed her claims.

> *"I have no problems sharing with my co-workers but it's not something I bring up a lot. If something interesting happens, I will share with the co-workers I believe are tolerant and open…. Getting into an argument about what I saw vs what they know I saw, just fosters feelings of anger."* (Participant 03)

One of the participants felt the conversation placed her in a vulnerable position, while another felt it was difficult to share a spiritual event with those outside her faith.

> *"If the topic comes up, I may mention it and my feelings. It doesn't often come up in general conversation and perhaps there are some I wouldn't mention it to here*

at work at all even though I feel I am an open person. It seems a vulnerable conversation at least." (Participant 04)

"As a nurse, it is easy to share these experiences because it is natural language in our profession. It is most difficult to share the spiritual "belief" when sharing the event with people who do not share the same belief." (Participant 05)

Time constraints and differing beliefs sometimes made it difficult for participants to share their experiences. All but one participant talked with others about the phenomenon and most valued the opportunity to discuss and validate their experiences within the professional community. Some found the discussion to be vulnerable to disbelief and criticism.

Summary

The study gathered data through asynchronous emails over six months. Initial contact with 13 participants resulted in six completed interviews and two partial interviews. Participants included a nurse educator, a floor nurse, a CCU nurse, two hospice nurses, and a hospice and floor nurse. Three major categories of themes based on the interview questions were: the interplay of personal history, spirituality, and a call to nursing, the profound experience of ELDVs on the dying and nurses, and navigating the intersection of life, death, spirituality, and nursing philosophy.

Participants often described their choice of nursing as a profession as a deep-seated, almost predestined path, as one nurse described it as a "true calling". Other participants expressed sentiments such as "Nursing chose me" and "God chose me at an early age and foreknew my life's work," suggesting a profound sense of purpose as a matter of course in their career choice. The theme of being called was strongly noted

from the descriptions of participants feeling a natural inclination towards caregiving from a young age. One of the more poignant stories was of a nurse recounting how her father discouraged her from pursuing her life dream of being a carpenter and chose nursing for her. This example accentuates the influence of her father's expectations in shaping her career path.

This first category of the interplay of personal history, spirituality, and a call to nursing shows a strong correlation between feeling called to the nursing profession, an innate desire to care for others, and the ultimate decision to become a nurse. This sense of calling and dedication to caregiving appears to foster an environment of acceptance and compassion, particularly when providing care for the dying.

The second category of themes of the profound experience of ELDVs on the dying and nurses was that participants shared experiences of dying patients having visions, feeling peaceful, and seeing auras within their patients and visions of deceased relatives. Common themes included patients feeling reassured, making gestures, seeing an inner light, having premonitions, and waiting for loved ones to arrive or leave before passing.

The third category of navigating the intersection of life, death, spirituality, and nursing philosophy is that participants found meaning in their experiences, the nurse's role as guide, how it affected their relationships, and sharing the experience with co-workers, They shared how a witnessed death phenomenon has impacted their views of life, death, spirituality, and their roles as caregivers.

In this sample of mainly Christian nurses from Western Massachusetts the recounting of stories of childhood experiences, ranging from difficult to happy do not

seem to be correlated with witnessing an ELDV. All the participants who had provided completed interviews had some religious or spiritual upbringing, which influenced their openness to deathbed phenomena. For many, it affirmed their childhood faith. The role of a nurse, as a guide, during the dying process is to support the dying person, families, and co-workers, encouraging them to be open to a spiritual experience.

Additionally, most participants did not seek spiritual support from clergy, and sharing their experiences with co-workers was common but depended on colleagues' openness and receptivity. Experiencing an ELDV reinforced the participants' belief in an afterlife and the importance of addressing death openly. Some participants felt the need to communicate their wishes about their own death with family members and the importance of saying what needs to be said before it's too late.

Nursing plays a crucial role in providing holistic care for the dying patient and supporting loved ones and co-workers. The study highlights the profound effect of witnessing an ELDV on a nurse's personal beliefs and professional lives. It accentuates the need for spiritual sensitivity in nursing care.

Chapter 5

DISCUSSION

The purpose of this qualitative study was to explore the lived experience of nurses who have witnessed the ELDVs of dying patients. A sample of six complete interviews and two partial interviews were collected.

During online interviews, the participants explored the meaning behind the phenomenon they observed as they reflected on how it may have affected them personally and professionally. For these participants, who were mainly caucasian Christian nurses from Western Massachusetts, witnessing an ELDV was a "profound" experience that, for many, affirmed their beliefs about life after death and helped to broaden their nursing care of the dying as they guided their patients and loved ones through the spiritual process of dying. Participants shared multiple stories of ELDVs, contributing to the data's richness and reaching saturation as stories started to align under similar themes. These themes were very similar to those already in the literature.

Some of the major categories coming out of the lived experience of this small group of nurses included the interplay of personal history, spirituality, a calling to nursing, and the profound effect of ELDVs on the dying and nurses and navigating the intersection of life, death, spirituality, and nursing philosophy.

The themes extracted from their earlier background included dysfunctional family vs. happy childhood, church, religious education, spirituality vs. discouragement in organized religion, and chosen/called vs. practicality.

Themes around the actual ELDV included anticipating a trip, inner light, experiencing a premonition, waiting for loved ones to leave or arrive, spiritual guide,

feeling peace and love, near-death visions from a nurse who did not complete the full interview, deeply affected, and spiritual support from a chaplain.

The themes included the transition of existence and belief in the afterlife/heaven, perceptions of fear and comfort with death, nurses' role as guide, say what you need to say, and sharing with co-workers about the phenomenon.

Background

Dysfunctional Family vs. Happy Childhood

Of the six participants who completed the full interview, three had discussed growing up in a dysfunctional family, citing domestic abuse, alcoholic parents, and divorced parents. The other three identified more with a happy childhood, close family relationships, and many school friends during an "idyllic time" in America. There appears to be no correlation between childhood experiences and witnessing a deathbed phenomenon. Just as the participant may have had a negative childhood, they also experienced ELDV that were positive, affirming, and profound in their lives.

Only in one case did a participant describe an additional story of her dying mother, who was struggling with terminal agitation, negatively responding to a deathbed vision that the nurse interpreted as the presence of her abusive father, causing the nurse to be angry. This nurse's anger elicited questions of the validity of earlier religious teachings on heaven and hell as well as punishment for misdeeds in life. One of the nurses shared that having a difficult childhood made her more spiritually aware, which motivated her to help others. Though having a positive or negative childhood does not appear to affect the chance of witnessing an ELDV, based on this study, childhood experience may influence

the interpretation of the deathbed phenomena. The review of literature does not appear to show another study that explored this possible correlation.

Church, Religious Education, Spirituality vs. Discouragement in Organized Religion

All participants were raised in some form of organized religion, the majority being Catholic. Early religious exposure provided a foundation for their spiritual beliefs and practices. Though some participants expressed discouragement about organized religion, they referenced back to religious ideas and spirituality when talking about what they believed was happening to the dying patients experiencing ELDVs.

This result shows some differences from Santo et al.'s (2017) study, suggesting that healthcare workers' religious beliefs did not impact how they perceived an ELDV as a spiritual event. The results are more in line with Grant et al.'s (2021) study of family caregivers in the United States, which found caregivers made more sense of ELDVs through religious and spiritual means. For the majority of the nurses in the study presented here, witnessing an ELDV was very affirming of their faith, and there appears to be an association between being raised in a religious home that stresses spirituality and openness to acceptance of a deathbed phenomenon.

Calling vs. Practicality

It was interesting to note that several participants described an intrinsic need to care for others and feeling "chosen" or "called" to nursing. As one nurse described it, she felt that nursing "chose" her, suggesting that nursing in itself may have a predestined path or divine vocation. This, in turn, creates within a nurse an acceptance of the calling and an openness to treating the dying. Florence Nightingale, around her 17th birthday, also wrote of God speaking to her and being called to the service of nursing (Snowden et al.,

2010). In a study by McKenna et al. (2023) of Indonesian nurses' and nursing students' motivation for entering the nursing profession, both groups were primarily motivated by a desire to serve others and God, personal calling, and the influence of family members and others.

Participants' practical considerations included job stability and the ongoing need for nurses. The nurses' practical reasons also coexisted with an authentic desire to provide care and support for the dying and their families. The convergence of spirituality, as well as a calling to nursing, creates a unique nursing identity when it comes to caring for the dying.

End of Life Dreams and Visions Witnessed

Anticipating a Trip

The finding of patients talking about catching a train, driving an old truck, or the immediacy of needing "to go" supports the idea that the dying sense that they are leaving to go somewhere else. Though the physical body remains, an aspect of themselves departs this life. This theme of traveling was noted in several studies in the review of literature (Kellehear et al., 2012; Komp, 1992; Muthumana et al., 2010; Nyblom et al., 2022. These stories included an eight-year-old Indian girl preparing to leave with her grandmother, which is similar to our participant's story of the adult child on hospice suspected of leaving with her grandmother as she was having visions of seeing her grandmother days prior to her death and suddenly dropping dead after insisting the she "had to go" (Muthumana et al., 2010).

In Komp's (1992) study, an eight-year-old boy discussed a dream in which Jesus pulled up in a yellow bus, inviting him to board. This study is similar to the elderly

gentleman talking about hearing a train and fearing missing it. Another patient in this study discussed a need to travel in his truck. Most likely, the means of transportation relates to what the dying patient identifies with in life.

In a telephone interview with Dr. Raymond Moody (2024), he also noted the theme of traveling from the stories that people were sharing with him. According to his theory of NDE, there is no time or space, yet there is a sense of traveling. He goes on to say that you cannot connect how the other world is connected to this world as it is an unintelligible axis (Moody, personal communication, 08/07/2024).

At times, it also appeared that nurses and families could help patients move on by reassuring them that it was okay to pass on. Examples of this are the family telling the gentleman to get on the train, placing the truck keys in the dying man's hand, or the nurse setting the patient's mind at ease that the family would be 'okay' if she passed on.

The reassurance suggests that for some patients, leaving loved ones can be challenging, possibly from fear or anxiety, if they will be okay without them. Giving that permission appears to release whatever anxiety or misgivings they may have of leaving and allow them to pass on. The prolonging of life by a body that has yet to enter the final stages of death may also inhibit the person from being able to travel on.

Inner Light

It is interesting to note that the observance of inner light was witnessed not only by nurses of dying patients but also by a patient referring to a vision of people in her room floating near the ceiling. This suggests that a person's state of mind, with or without dementia, does not contribute to the experience itself.

Age is also not a factor, as one of the nurses observed a 'golden aura' around the vision of her grandmother as a child. In Brayne et al.'s. (2008) research, families in the United Kingdom who were actively involved in the dying patient's care discussed a light surrounding the dying person that emitted feelings of love and compassion. Dr. Moody (2024) also noted that he, himself, had witnessed a dying patient glowing.

Experiencing a Premonitions

The anecdotes shared in this study by two nurses who had a premonition of their grandmother's dying are remarkably similar to stories found in the review of literature. Similar to the narrative from the research by Brayne et al. (2008) about a woman waking from a dream that her mother was dying, one of our participants spoke about having an intense dream of her grandmother dying. Both dreams accurately described a real event that was occurring. It also allowed both women to go be with their loved ones as they passed.

In the second case, a participant, as a child, saw a vision of her dying grandmother at the end of her bed. Fenwick and Brayne (2011) also shared a similar story of an 11-year-old's dead grandmother appearing at the end of the bed. Dr. Moody & Perry (2019) described how a woman died on the operating table during a heart transplant and traveled to her son-in-law's home, standing at the end of his bed, letting him know that she was going to be alright.

In the case of the woman with a lumbar fracture who was going to meet her dead sister for lunch, she unwittingly may have predicted her own death. The patient sounded excited to see her sister, no longer thinking that they were in two different states of

existence, and then closed the separation gap by suddenly passing away from a massive myocardial infarction.

From the data collected, it appears that dying patients are able to travel outside of their bodies to their loved ones with a message of warning or comfort. Brayne et al. (2008) and Santos et al. (2017) determined from their research that loved ones were visited by the dying person as a way to say "goodbye." According to Dr. Moody, the visions of dead loved ones appearing to living relatives are an SDE (Moody, personal communication, 08/07/24).

Waiting for Loved Ones to Leave or Arrive

The phenomenon of patients waiting for loved ones to arrive or leave is noted in this research and literature review. One participant in this study noted that in her experience, she 'often' sees dying patients doing this. Claxton-Oldfield and Richard's (2022) study reported dying patients waiting hours or days for loved ones to arrive, even in the throes of death. This observation by Claxton-Oldfield and Richard (2022) complements the experience of the nurse in this study who witnessed the Indian grandmother waiting for her grandson to arrive even though she was actively dying, had agonal breathing, and no longer had a blood pressure.

The third example under this theme spoke of a mother encouraging her daughter to leave with her family for a meal and, in her absence, allowing herself to let go. It appears that the mother, who was close to her daughter, chose a time in which the daughter would be spared from watching her die. It seems once again to reflect an act of maternal affection towards their child as they near the end of life. These stories suggest that, to some extent, dying patients may have some level of conscious control over when

their passing occurs. Even when death is imminent, the patient appears to delay it until a moment of their choosing.

Spiritual Guide

The role of a guide from life to death is not a new concept. Greek mythology spoke of a ferryman, Charon, who would row peoples' souls over the river of Styx and Acheron into the Underworld (Britannica, 2024). The participants of this research strongly suggested that dead relatives or someone that the dying patient knew guided them into the next world. Brayne et al. (2008) research supports this theory as participants in their studies suspected that dead relatives were actively involved with the dying patient in transitioning into death and beyond. Moody & Perry (2023) also noted that loved ones were able to see dead family members around the dying person's bed and watch them leave together during an SDE.

A Feeling of Peace and Love

A feeling of peace or serenity during the dying process almost seems counter-intuitive to the expectation of death. The dying process can be labor-intensive and, for some, fraught with suffering. Advancements in medicine and nursing have helped individuals control their pain better and lessen or eliminate suffering in end-of-life care. The peace surrounding a dying patient, as described by witnesses, is similar to what is described by the Apostle Paul in Philippians 4:6, as a peace that surpasses all understanding (The Holy Bible, 2011). Participants in this study described dying patients as having an aura of peace around them that was palpable to the observers and expressions of peace such as smiling and showing a lack of fear. It was also helpful for a dying patient's daughter to see that despite having a dramatic rupture of an abdominal

aortic aneurysm, her mother was peaceful until the end. After witnessing her at peace, the daughter was finally able to accept her passing and let go.

Several researchers noted a "profound love" around the dying as well as peace (Brayne et al., 2006; Brayne et al., 2008; Either, 2005; Fenwick et al., 2007; Fenwick et al., 2010; Kubler Ross, 1971; Nyblom et al., 2021; Osis & Haraldsson, 1977). A participant in this research described feeling "much love" in the room and "feeling surrounded by it". How a dying person may witness or experience peace and love during the dying process may not be fully understood using science. It may be explained better by a religious and cultural epistemology.

Christian doctrine describes the fruits of God's spirit, including love and peace (King James Bible, 2011, Galatians 5: 22-23). For some of the participants in this study, their Christian faith provided sound reasoning for explaining the different emotions. As one participant described the ELDV, the patient was being hugged by Jesus and St. Mary and welcomed into heaven by God. For Christians, all of these heavenly beings are believed to be imbued with God's Spirit. For others, it may just be the dying person's acceptance of death and transcendence into the afterlife. In Renz et al. (2015), dying patients described a "pure energy," "color," "light," or "spirit" that brought them peace. The calmness of a dying person may elicit a calming feeling in people around them. It is unclear if the origin of peace and love emanates from within the dying person, if something manifests these emotions around the person, or if it may be an amalgam of both.

Deathbed Visions

Though the participants in this study did not actually see the visions that dying patients were having, they described the behaviors of their patients responding to the visions. Nurses described patients reaching for their vision and talking to someone in the room who was not visible to the family and nurse. The patient who died in CCU reached out her arms as if to hug someone and stated, "There you are," suggesting that they were familiar with them, maybe even waiting for them, and very happy to see and depart with them as she flat-lined at that instance. Articles by Sir Barrett (1926), Claxton-Oldfield and Richard (2022), and Osis and Haraldsson (1977) also noted dying patients being observed calling out to their vision, talking with them, smiling, pointing to them, and reaching for them.

In some cases, the nurse and family members had a sense that the vision may include family members such as a grandmother, mother, aunts, husband, and possibly angels, such as in the case of the "shining" people. The research outlined in the literature review supports their assumptions as they described dying people often recognizing the visitors as family and friends (Sir Barrett, 1926; Brayne et al., 2008; Claxton-Oldfield & Richard, 2022; Dam, 2016; Ethier, 2005; Muthumana et al., 2010; Nyblom et al., 2022; Osis & Haraldsson, 1977; Santos et al., 2017). Dr. Morse (1994) identified a religious connection between Muslims seeing Allah and Christians seeing Jesus and angels. Children were particularly aware of religious figures visiting them, and Swiss patients identified light and angels (Dos Santo et al., 2017; Komp, 1992; Renz et al., 2018).

These findings also supported Ethier's (2005) research, which noted that Americans' visions were mostly female. In this study, three participants mentioned

grandmothers; two were mothers, and one was a sister. Only one case mentioned a husband.

In the case of the two women seeing the 'people' near the ceiling, the women were perplexed that the nurse was not able to see them. In most cases, the nurses described the patients as being lucid and having appropriate conversations while seeing visions. One of the participants reflected later that she wished she had asked more questions, which may have helped answer who or what the visions were. In all cases but one, the visions were comforting and elicited joy and happiness by their presence along with excitement, such as the woman joyfully explaining that she was meeting her sister who had passed earlier to have lunch.

In the interview with Dr. Moody (2024), he was asked if the nurses who were witnessing the physical gestures or deathbed phenomenon were experiencing an SDE, as they did not see the visions themselves. He agreed that this was not an SDE but something else. The term "witnessed deathbed phenomenon" was agreed upon as a more descriptive term. This term indicates that the nurse is witnessing a profound deathbed phenomenon without having an SDE. The nurse is not seeing the vision or crossing over with the dead into the next world but is witnessing the patient have the experiences and being emotionally and physically affected by it.

Death Bed Visions from a Nurse Who Did Not Complete the Full Interview

One of the more perplexing cases was the nurse who had three different residents in a long-term care facility discussing seeing children in their rooms. The vision of the children was also followed by two of the three patients unexpectedly passing away. When

discussing the case with Dr. Moody, he had not heard of an incident like this before and could not suggest what the incident could be or mean (Moody, personal phone call, 08/07/24).

As unusual as this story may be, in a study by Brayne et al. (2008), a nursing home patient told a care assistant about seeing children running by her window even though her room was on the second floor. Just as the vision of children in the story disturbed one of the residents in the USA, the children were a comfort for a resident in the UK.

Deeply Affected

For all the participants of this small study, witnessing an ELDV was profound. The nurses used words such as emotional, profound, life-changing, amazing, powerful, peaceful, affirming, awe-inspiring, humbling, happy, reassuring, joyful, mesmerizing, unafraid, loving, and private to describe the ELDV experience. Healthcare providers in Camden, England, also described the ELDVs as calming, soothing, comforting, beautiful, and quieting (Brayne et al., 2008). One of the participants could not find words to describe her experience, and said that it was inexplicable. Dr. Moody (2024) also mentioned that many people who have an NDE or SDE say that it really is indescribable. There are no words to describe what happened to them.

When discussing with Dr. Moody (2024) about the case of the CCU nurse and Cardiologist who witnessed a dying patient reaching out to hug someone and joyfully greeting them, he believed that they both had experienced a shared death experience. At that moment, the nurse and Cardiologist entered with the dying patient in a united state of consciousness, which is why they both had such a visceral response.

Navigating the Intersection of Life, Death, Spirituality, and Nursing Philosophy

Transition of Existence and Belief in the Afterlife/Heaven

Many participants reflected on the nature of death, describing it as a transition of existence from a living, physical being on earth to a spiritual being in death. This process was often viewed as a journey where the physical and spiritual worlds intersect as patients "cross over." Participants expressed a belief in the duality of human existence, being both physical and spiritual, and described the dying process as a moment where these two realms converge.

For instance, one participant shared that their religious background, combined with their nursing experience, led them to believe in a spiritual world or Heaven. This spiritual realm might be more felt than seen, and as life slips away, individuals draw closer to this "other world," experiencing phenomena unseen by others except as spectators. Others echoed this sentiment, describing a connection between the physical world and the afterlife, with the spirit, body, and mind preparing for the next chapter. The transition was often depicted as a peaceful process, akin to a family reunion or guided journey, with one participant referring to this phase as "God's waiting room."

This belief in a continued existence beyond physical life was further reinforced by reflections on End-of-Life Dreams and Visions (ELDVs). Many participants believed in the concept of heaven and an afterlife, seeing death not as an end but as the start of "the next great adventure." Witnessing ELDVs confirmed their belief that death is a guided experience, with loved ones and spiritual beings helping to usher the dying toward a positive destination.

One recurring theme was the opportunity for spiritual reconciliation during the dying process, where individuals might connect with a higher power, or God, in their final moments. Participants expressed hope that even those who might not have been spiritually inclined during their lives could find salvation at the end through divine intervention. This belief provided comfort and reduced anxiety about the deaths of loved ones and their own eventual passing, as they felt reassured that death was a transition to a better place, guided by a higher understanding. Overall, the participants' reflections highlighted a profound belief in the continuity of existence, where the physical and spiritual realms intersect at the end of life, leading to a peaceful transition to the afterlife.

According to Dr. Moody, the shared death experience (SDE) supports the experiences of some participants in this study (R. Moody, personal communication, August 7, 2024). After taking part in the SDE, participants felt that they had witnessed something profound, amazing, and powerful. Though the nurses in this research did not all have an SDE, many shared emotions and wonderment similar to those who did.

Nurses' Role as Guide

The participants acknowledged the perception of fear and comfort about death and dying patients and family members. They stressed the importance of understanding and accepting the deeply personal and varied responses in their uniqueness and caring for them with empathy and compassion. They recognized the range of emotions towards death, from anger and fear to acceptance and peace. The participants viewed themselves as guides, offering opportunities for dialogue about ELDVs and the next life during and

after the dying process. One of the participants discussed the importance of being present at the patient's death as an integral way to provide holistic care.

As educators, the participants felt strongly responsible for educating patients and families about the dying process, which included discussing experiences such as ELDVs to bring comfort and understanding. The role of the nurse included providing spiritual and emotional support. Their own nursing philosophy included their faith values, emphasizing the importance of treating every patient with dignity, love, and respect. The participants talked about alleviating fear through preparing and educating dying patients and families about what to expect and providing comfort when suffering. These nurse viewed their role with the dying and their families as one of guidance and supporting the emotional and spiritual aspects of dying, ensuring a dignified and peaceful end-of-life experience.

Nurses Need to be Open to the Spiritual Side of Death

The participants discussed the importance of nurses being open to the spiritual dimension of death, especially when encountering an ELDV. Regardless of personal beliefs, recognizing and respecting a deathbed phenomenon is seen as crucial in providing compassionate care. This openness helps to protect and validate the patient and family members' experience, as well as fostering a supportive environment during the dying process.

The nurse's early life experiences in religion appear to support their belief in spirituality and the afterlife. Though one participant emphasized the importance of not

imposing her beliefs on the patient, She was open to discussing spiritual matters if the patient initiated the conversation or was having fear and anxiety from experiencing an ELDV. Other participants were more open to freely sharing ELDV experiences with dying patients and caregivers without being prompted into discussion. Though the nurses did not always stress that they fully understood what ELDVs mean, they felt it was important to be open to the experience so that the patient and family may feel understood and comforted, even in the presence of the unknown.

Say What You Need to Say

The experiences with End-of-Life Dreams and Visions (ELDVs) had varied impacts on participants' relationships with others. One participant felt that her experience did not affect her relationships at all, as her family, friends, and co-workers showed little interest or concern. In contrast, another participant found sharing her ELDV experience helpful, particularly in her nursing profession, as it validated her experiences and supported colleagues who were grappling with similar situations. Two other participants noted that their experiences prompted them to think more deeply about their own death and to communicate their end-of-life wishes to loved ones, which provided a sense of control and comfort. Additionally, one nurse reflected on her regret over not having more meaningful conversations with her sister-in-law before she passed away, which led her to prioritize saying important things to her loved ones before it is too late. Overall, ELDV experiences influenced participants to communicate more openly about death, share their wishes, and ensure meaningful conversations with loved ones.

Sharing With Co-Workers About the Phenomenon

The mixed responses from participants about sharing their ELDV experience with co-workers revealed several underlying themes about the nature of these experiences and the workplace environment in nursing. One of the participants noted the lack of time to share the experience due to the busy nature of nursing work, suggesting that the healthcare environment prioritizes bedside duties over time for reflection and mourning the death of a patient. Though the fast-paced work of a nurse and patient turnover is necessary to provide ongoing healthcare for the sick, it may speak to a systemic issue of not addressing the impact that the death of a patient may have on nurses, especially one that is personal and profound.

The reluctance of some participants to share their experiences with certain colleagues points to the vulnerability associated with ELDVs. Some participants described the discussion of ELDVs as having a spiritual meaning and deeply personal. This vulnerability leads to selective sharing, where participants choose to confide only in those who they believe would be accepting and open. This suggests that witnessing an ELDV is not just a clinical experience but is intertwined with one's personal belief system and emotional responses.

For some participants, they expressed a desire to discuss and validate their experiences within the professional community. The desire of these participants to share such a significant event suggests a need for a professional space in healthcare environments where nurses can openly discuss their experiences, receive support from the medical community, and be free of judgment. The voiced concerns from the participants about encountering disbelief or dismissal by colleagues accentuate the

diverse belief system within the nursing profession. With the biomedical model being strongly emphasized in nursing, experiencing an ELDV, which for many is seen as a spiritual or paranormal event, may be difficult to comprehend and accept.

This lack of acceptance by nursing colleagues may lead to potential conflicts and isolation of nurses who witnessed ELDV. This indicates a broader challenge within healthcare of accommodating nurses' diverse beliefs and experiences, especially those not explained within the scientific or clinical framework. Nurses may also search for validation from the broader community.

In a 2015 TEDx Talk, Dr. Chris Kerr, Chief Medical Officer of Hospice & Palliative Care Buffalo, discussed ELDVs. The talk garnered millions of views and thousands of comments, many from nurses expressing gratitude for the validation of experiences they have long recognized in their work (Zerwick, 2024).

Nursing and Philosophy

In simple terms, philosophy is the study of "the basic ideas about knowledge, truth, right and wrong, religion, and the nature and meaning of life. (Merriam-Webster, 2024). The evidence in philosophy consists of the individual's experience, observations, mental states, state of affairs, and physiological events (Internet Encyclopedia of Philosophy, 2024). According to Cheraghi et al. (2019), philosophical thinking in nursing enhances knowledge, insight, and competence.

They go on to say that by integrating philosophical attitudes, nurses can better comprehend the holistic nature of patient care, seeing patients as integral wholes and

fostering professional and compassionate care. Their study highlights the importance of creative thinking in nursing education and that philosophical thinking is crucial for developing skills, insight, and competent nurses (Cheraghi et al., 2019).

Nursing is science driven by evidence-based practice. Evidence-based practice is valuable for nurses for several reasons. It improves patient outcomes, enhances nursing practice, promotes quality and safety, supports professional development and scientifically supported research, increases efficiency and cost-effectiveness, meets accreditation and regulatory standards, and empowers patients (ANA, 2023). With that being said, is there a place for a philosophical experience in nursing? Nurses for decades have talked about experiencing end-of-life dreams and visions of dying patients, yet it is neither discussed in nursing texts nor taught in nursing education. It is seen as a taboo subject and easily dismissed due to the lack of empirical evidence, yet it exists.

According to Dr. Moody (2024), people do not discuss NDE, SDE, and ELDVs because:

> "*Most people still don't like to talk about life and death. It's a way of denial; deep down, they think, well, if I talk about it, I might bring it on."*

After speaking with Dr. Moody (2024) and listening to an interview with Dr. Donna Thomas by Essentia Foundation (2024), the explanation of what these participants experienced with ELDV cannot be explained by science. Both scientists agree that an explanation of the deathbed phenomenon lies within the nature of consciousness. It searches the ontology of who and what we are. If we believe that all we are is a biological being, then we can only deduce that the participants' and dying patients' experiences are

related to bioscience. If we explore the phenomenon philosophically, we may entertain the notion of a *universal consciousness*.

Dr. Moody (2024) mentioned that the most philosophical people he had ever met were often nurses. Nurses are trained in the bio-science of care but often may experience something that is not defined by nursing education. It is during these times of witnessing suffering and deathbed phenomena that questions and explanations may be found more in the paradigm of philosophy. All of the nurses in this research speak in a favorable way toward the witnessed deathbed phenomenon and its contribution to enhancing the holistic care of dying patients and their own personal lives.

Internet Interviews

Using online interviews via email was a convenient way to collect data while allowing participants to move at their own pace and within a safe space from unintentional judgment or bias by the researcher. The use of email in research has become more relevant since the COVID-19 pandemic and is shown to be cost-effective and coincides with the environmental shift of society to social media (Dahlin, 2021). Due to the participants' time constraints and for their convenience, all questions were provided at once. A summary of their work within themes was sent to the participants for validation, following Colaizzi's eight data analysis steps (Vignato et al., 2022).

While analyzing the participant's work, additional questions were sent out as needed to clarify previous responses. Having the answers by participants typed out in an email made it convenient to review their work several times for thematic analysis. The downside of using email interviews vs. in-person was the lack of assessing body language and spontaneous conversations, which might have led to more insight into their

experience. It also prevented a human connection between participants and the principal researcher, which would have allowed participants to receive acceptance and validation of their experience.

Strengths and Limitations

A key limitation of this qualitative study was the lack of religious diversity among participants, including the absence of atheists. This may be attributed to the small sample size and the use of a convenience sample of nurses from Massachusetts, where 58% of the population identifies as Christian (Pew Research Center, 2014). Four of the participants were raised in the Catholic Church, and the remaining two were raised in other Christian denominations. Given that deathbed phenomena are often linked to spirituality and the world of metaphysics, a Christian upbringing may have influenced participants' interpretations. As a result, this study lacked the diversity needed to explore how individuals from different religious backgrounds, or those without religious affiliations, interpret what they witness during such experiences.

It was exciting to note that several of the anecdotes provided by the participants were similar to the data found in the review of literature. This repeated data strongly supports the validity of the participants' accounts and their discernment of the events. Another limitation was starting the research before the two major holidays of Christmas and New Year. With the holiday, a nurse manager reported a high volume workload of several potential participants. However, using email allowed participants the freedom to find a convenient time to complete the interviews within their own time frame, which would not have been possible if we insisted on face-to-face interviews.

A strength of the study was the richness of the stories and deep reflections by the participants. The participants brought depth, complexity, and multidimensionality to their narratives, which were, at times, thought-provoking and emotional, as their stories were candid and thematic. The use of Husserl's philosophy of phenomenology was also valuable as the participants' experience moved beyond the natural and physical world to spirituality.

Conclusion

This qualitative study delved into the profound experiences of nurses who have witnessed ELDVs of dying patients, exploring the personal and professional impact of these occurrences. The study revealed that these experiences were deeply significant, often reinforcing the nurses' beliefs in life after death and broadening their approach to nursing care at the end of life. The narratives provided by the participants were rich with themes that included their personal history, spirituality, the unique calling of nursing, the profound effect of ELDVs, and navigating the intersection of life, death, and nursing philosophy.

One of the key findings was the interplay between the nurses' backgrounds in religious education and their openness to spiritual experiences, such as ELDVs. Despite varied Christian affiliations and levels of engagement with organized religion, the majority of participants found these visions to be affirming of their spiritual beliefs. The sense of being "chosen" for nursing also emerged as a powerful theme, highlighting the intrinsic motivation that many nurses feel in their role, especially in the context of end-of-life care.

The study also uncovered a range of phenomena associated with ELDVs, including patients anticipating a journey, the presence of an inner light, and the involvement of spiritual guides. These experiences were not only significant for the patients but also left a lasting impression on the nurses who witnessed them, often bringing a sense of peace, love, and fulfillment to the otherwise challenging experience of death.

Furthermore, the participants' reflections on their role as guides during the dying process underscored the importance of a holistic approach to nursing that embraces the spiritual dimensions of death. The nurses emphasized the need to be open to these experiences, providing compassionate care that honors the spiritual needs of both patients and their families. The study highlighted the potential for ELDVs to facilitate meaningful conversations about death, encouraging nurses to engage in open dialogue with patients and loved ones, thereby enriching the dying experience.

The occurrence of ELDVs cannot be explained by science but needs to look at a more philosophical explanation entertaining the idea of a universal consciousness (Moody, 2024; Essentia Foundation, 2024). The concept of a metaphysical explanation for the nurse’s experience with deathbed phenomena is not a radical idea as some grand theorists in nursing, such as Martha Rogers, described the constant exchange of energy and matter between the environment and the unitary human being, who is integral with the universe (Nurselabs, 2024). Sister Callista Roy’s Adaption Model included the philosophical assumptions that each person has a mutual relationship with the world and

God and that human meaning is found in the “omega point convergence of the universe” (Nurselabs, 2024).

Despite the small sample size, the richness and thematic consistency of the participants' narratives contributed to the study's validity and depth. The findings suggest that ELDVs are a significant aspect of the dying process that can enhance the quality of care provided by nurses. Moreover, the study calls for greater recognition and discussion of these phenomena within the nursing profession, advocating for a more inclusive approach that integrates spiritual experiences into the broader framework of nursing care.

In conclusion, this study illuminates the profound impact of witnessing ELDVs on nurses, affirming the importance of spiritual care in nursing and underscoring the need for further exploration of these experiences in both research and practice. The narratives of the participants not only contribute to our understanding of the intersection of life, death, and spirituality, but also offer valuable insights into the compassionate care of the dying, ultimately enriching the field of nursing with a deeper appreciation for the holistic nature of end-of-life care. Many of the participants’ anecdotes match data found in the review of the literature and bring validity to a universal experience of deathbed phenomena.

Direction for Future Research

The following are recommendations for future studies:

1. It is recommended that future research should include a more religious diverse group of participants to explore whether ELDVs appear differently or hold varying significance across a wider range of belief systems.

2. It is recommended to recruit nurses from different branches of nursing, including nursing assistants, to enhance the richness and depth of the data.
3. It is recommended to include an incentive to attract and maintain interest in the study, as time is a precious commodity for many nurses.

Teaching Opportunities for Nurses

Information about ELDV is lacking in both nursing texts and education. There is a disconnect between nursing and philosophy, which hasn't always been there, as evidenced by Drs. Rodgers and Roy's work in nursing theory. Nurses continue to be leaders in STEM research, developing new ways to better healthcare through advanced science and technology. According to Pilla (2024), Rebecca Love, co-chair of Nursing in STEM Coalition, classifying nursing as STEM could allow Universities up to $1.2 billion in funding.

Which leads to the question of are we balanced as a profession if our focus becomes more on science without attention to the art of caring for people? Are we seeing nurses today spending less time actually touching people and being at the bedside and more time on computers and focused on medication? Is there a growing discourse between seeing patients as something you work on vs. someone you work with?

Teaching on ELDVs requires nurse educators to reevaluate the direction of nursing education and if we are balanced in the science and philosophy of patient care. If nursing educators continue to find the subject of the deathbed phenomenon taboo and unsupported, then little effort will be made to explore the experience of nurses and patients for generations. This questions the holistic nature of patient care at the end of life.

To introduce ELDVs into nursing, we must begin with collegiate support. Nursing educators must begin to assess the mounting global evidence of NDE, SDE, and the witnessing of deathbed phenomenon. It is not the introduction of a new concept but the examination of something that has always been there. It is with an open mind and heart that nursing care among the dying may include future nurses being aware and prepared for encountering ELDVs and being guides for their patients and loved ones.

Education on ELDVs may also be included in ongoing education to help dispel any anxiety, fear, and confusion of nurses when they witness a deathbed phenomenon. Exploring universal consciousness may also help nurses reach a higher level of self-actualization when considering the self, how humankind is connected, and what it means to be unwell. On-going research on the topic, with a collegiately accepted platform, will help to make the lived experience of nurses and ELDVs less taboo and contribute to greater holistic care of the dying.

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APPENDIX A

RECRUITMENT POSTING

Recruitment Posting

Seeking Nurses Who Have Witnessed A Deathbed Phenomena Of A Dying Patient

I am conducting a research study on nurses' experience witnessing a dying patient's end-of-life dream, vision, or any unusual phenomena. Examples of an end-of-life dream or vision may include the patient seeing dead relatives, Allah, God, angels, or otherworldly sites. This also includes nurses witnessing paranormal phenomena such as sensing a presence or seeing a mist around the patient. Patients may also experience a "Lazarus moment" of becoming awake and alert from a coma and having sound conversations with those around them before death. The dying patient may also have this overwhelming need to make amends with their loved ones or show extraordinary strength to hold on to life while waiting for relatives or friends to arrive.

The study shall be conducted online through an exchange of emails over a 2-3 week period. You can anticipate being emailed 6-9 times to clarify any questions and ensure your testimony is interpreted as you intended. No anticipated risks are involved in this research, and all information will be kept confidential.

If you are interested, please email me at sherron@umass.edu

APPENDIX B

SURVEY ON DEMOGRAPHICS

Thank you for your interest in the study. Before you officially enroll in this research study, I will ask you to complete a questionnaire. It should take you no more than ten minutes to complete. This questionnaire is a screening tool that will ask you questions about your nursing license, experience concerning the phenomena, and comfort level to discuss your experience to determine your eligibility for participation in the study. The purpose of the study is to allow nurses the opportunity to share their lived experiences of witnessing end-of-life dreams and visions of dying patients.

If you are determined ineligible to participate, your completed questionnaire will be destroyed. If you are determined eligible to participate, the completed questionnaire will become part of the study materials, and we will protect your information as confidential and safeguard it from unauthorized disclosure. Only research personnel will have access to the information contained in your questionnaire.

If the questionnaire indicates that you are eligible to participate, we will proceed to obtain your written informed consent for participation in the study. If you have any questions, please email me at sherron@umass.edu.

Type of nurse RN/LPN? _____

What type of nursing were you doing at the time of the

incident?_____

Did you witness it yourself or hear about it from someone

else?_____

Did the patient die or continue living after the

experience?_____

Do you feel comfortable talking openly about the

experience?_____

Thank you for answering the eligibility questions. You will receive a response within 72 hours after returning the survey to sherron@umass.edu.

Sincerely,

Sherilyn Herron MSN-Ed, RN

APPENDIX C

INFORMED CONSENT

Online Interview Consent Form

[ ]

You are being invited to participate in a research study titled The Lived Experience of Nurses Witnessing End-of-Life Dreams and Visions of Dying Patients. This study is being conducted by Sherilyn Herron MSN-Ed, RN from the University of Massachusetts Amherst. You were selected to participate in this study because you are an RN/LPN who had first-hand experience witnessing a dying patient's end-of-life dream and vision (ELDV) and are open to sharing your experience.

Why are we doing this research study?

This research study aims to share the nurses' lived experience of witnessing an ELDV of a dying patient. This new information will contribute to the ongoing research of deathbed phenomena and may provide new nursing knowledge.

Who can participate in this research study?

Every RN or LPN who has experienced an ELDV is welcome to participate in this voluntary study regardless of age, sex, religion, culture, or work experience.

What will I be asked to do, and how much time will it take?

If you agree to participate in this study, you will be asked to complete an online interview that is made up of three parts. The three-part interview will ask about your life history, details of the experience, and reflection on the experience. Each part of the interview should take you no more than 15-30 minutes to complete and will be followed up with 3-4 more emails to clarify any questions and ensure your responses are reflected as you intended.

Will being in this research study help me in any way?

Participating in this qualitative study offers you an opportunity to share your story with other nurses.

What are my risks of being in this research study?

We believe minimal risks are associated with this research study; however, a breach of confidentiality always exists, and we have taken steps to minimize this risk, as outlined in the section below.

What if I wish to seek a professional counselor during or after sharing my experience?

Sometimes, discussing thoughts and feelings about past experiences prompts a need to talk with a professional counselor. If you feel in a depressed mood or have anxiety, you should discuss your thoughts and feelings with a professional counselor. We will gladly refer you to a Community Behavioral Health Center or a private therapist in your area. You may also want to contact your own professional counselor. We have listed below the phone numbers for Behavioral Health Centers located in Massachusetts.

Behavioral Health Help Line

"Community Behavioral Health Centers are closely connected to the Massachusetts Behavioral Health Help Line. The Behavioral Health Help Line is a 24/7 clinical hotline staffed by trained behavioral health providers and peer coaches who offer clinical assessment, treatment referrals, and crisis triage services. When appropriate, Help Line staff directly connect callers with their nearest CBHC and perform a warm handoff."

The Help Line is available in more than 200 languages, 24/7, 365 days a year.

Call or Text: **833-773-2445**

Web Chat: **masshelpline.com**

If, by your written material, there is a concern that you are at risk of harming yourself or others, we will, by law, need to dial 911 in order to get you the services you need.

How will my personal information be protected?
To the best of our ability, your responses to the online interviews will remain confidential. We will minimize risks by reviewing your interview only with committee members using One Drive and anonymously presenting results. According to the University of Massachusetts' IT department, One Drive is the most secure way to share documents. The participants' names and email addresses will also be kept in a One Drive document, and information stored on the laptop during research will be coded and unidentifiable to others. Access to the primary researcher's computer is limited only to the researcher and is locked when not in use. Once the study is completed, data will be safely stored by Elaine Marieb School of Nursing at the University of Massachusetts Amherst. Although no names or identifying information will be released to anyone, quotes may be used in the dissertation as well as published work.

Will I be given any money or other compensation for being in this research study?
There will be no money or compensation for being on this research study.

What happens if I say yes, but change my mind later?
You do not have to be in this study if you do not want to. If you agree to be in the study but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

Who can I talk to if I have questions?
If you have questions about this project or if you have a research-related problem, you may contact the researcher(s) at any time.

Sherilyn Herron, (413) 426-6603, sherron@umass.edu Doctoral Candidate

Dr. Pamela Aselton, paselton@umass.edu Chair of the Doctoral Committee

If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

By checking "I agree" below, you are indicating that you are at least 18 years old, have read this consent form, and agree to participate in this research study. You are free to skip any question that you choose.
Please print a copy of this page for your records.

I Agree ☐

I Do Not Agree ☐

APPENDIX D

CONTACT SUMMARY FORM

Name	ID #	Date/ E-mail/ Summary of Contact

11/23 Sherilyn Herron (SH)