BRIEF REPORT

A Near-Death Experience with Veridical Perception Described by a Famous Heart Surgeon and Confirmed by his Assistant Surgeon

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ABSTRACT: The professional near-death literature contains cases in which near-death experiencers reported that during their experiences (NDEs), they perceived phenomena in the material world that, based on the condition and position of their physical bodies, they should not have been able to perceive, and yet these perceptions were subsequently verified as accurate. Only a few of these cases of apparently non-physical veridical perception during NDEs have been carefully researched. In this article, we report a case described originally by cardiac surgeon Lloyd Rudy in a YouTube Internet video. We describe our process of following up exhaustively on all avenues of investigation available to us and our conclusion that this case is among the most evidential in which perceptions during an NDE were confirmed as completely accurate by objective observers.

KEY WORDS: near-death-experience, veridical perception, cardiac valve resection surgery

As early as 1882, the professional near-death literature has contained accounts describing near-death experiences (NDEs) in which the ex-

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periencer, upon regaining consciousness, reported perception during the NDE that was later confirmed as accurate (Holden, 2009). When such perceptions should have been impossible based on the condition and position of the experiencer's physical body, they have been termed apparently non-physical veridical perception (AVP). The most evidential of these cases involve perceptions that seem impossible to attribute to sensory processes-such as vision or hearing-or to logical deduction or previous knowledge on the part of the experiencer. Upon gleaning the professional literature, Holden (2009) found 107 cases of AVP, of which 27% belonged to the most evidential category in which the perceptions had been verified as completely accurate by objective observers. We've been personally involved in a follow-up on one of these accounts, the case of the "Man with the Dentures" (Rivas & Dirven, 2010; Smit, 2008). A recent online case appears to add one more to that category; that case is the subject of this report.

On July 27, 2011, Mike Milligan, DMD (http://www.eastlanddental.com/) uploaded a fascinating video clip onto his YouTube account, dentalmastermind, entitled Famous Cardiac Surgeon's Stories of Near Death Experiences in Surgery (http://www.youtube.com/watch?v=JL1oDuvQR08). It concerns a segment taken from a larger interview Milligan had conducted with the late U.S. cardiac surgeon Lloyd William Rudy, Jr., M.D. (1934-2012) during a meeting of the American Academy for Oral Systemic Health (AAOSH) in June, 2011.

Rudy graduated from the University of Washington Medical School, completed a residency at the University of San Francisco Medical Center, and after serving in a M.A.S.H. unit in Vietnam became a Board Certified Cardiovascular and Thoracic Surgeon, was Dean of the Heart Program at the University of Georgia School of Medicine, and was a member of the first heart transplant team at Stanford University. The Governor of Montana proclaimed a Dr. Lloyd Rudy Day in honor of his pioneering work in cardiac surgery in that state. Interested readers may refer to his obituary: http://www.heritagefunerals.com/fh/obituaries/obituary.cfm?o_id=1464561&fh_id=11479)

In the YouTube clip, Rudy discussed two cases he had witnessed, the first of which concerned a classic NDE involving veridical perception during clinical death. Following is a transcript of this portion of the interview:

> RUDY: We had a very unfortunate individual who on Christmas Day had, from an oral infection, infected his native valve [gestures to indicate a valve of the heart,

with "native" referring to the patient's biological valve rather than an artificial, prosthetic valve]. If your native valve has the slightest defect, whether you were born with it or you developed it later—it calcified a little and the valve leaflets don't move or whatever—the body recognizes that as something abnormal that it's got to take care of. So that's what happened to this man, and one of my junior partners was on call, and he had to do an emergency valve resection. Once we were able to accomplish the repair of the aneurysm and the replacement of the valve, we could not get the person off of the bypass. Every time the four or five liters of blood that we were pumping around his body, we would reduce down to two or three, he'd begin to weaken and his blood pressure would go down, and so on. To make a long story short: We simply couldn't get him off the heart-lung machine. Finally, we just had to give up. I mean, we said: We cannot get him off of the heart-lung machine, so we're going to have to pronounce him dead. So we did that. And so the anesthesiologist turned his machine off and the bellows that were breathing for the patient stopped. That machine was quiet.

The anesthesiologist went into the surgeon's lounge. He hadn't eaten anything all day so he went in to have a sandwich. Then the people, who usually clean up the instruments and all that, were coming in and taking away all these tools. And my surgical assistant closed the patient in a way that a postmortem exam could be done, because anyone who succumbs on the table by law has to have an autopsy. So he closed him up briefly, with a couple or three wires here and a big stitch to close his soft tissue.

Well, that machine that records the blood pressure, and the pulse, and the left atrial pressure and all the monitoring lines and things, continued to run the paper out onto the floor in a big heap. Nobody bothered to turn it off. And then we put down a trans-esophageal echo-probe, which is just a long tube that has a microphone on the end of it, and we can get a beautiful picture on a monitor of the heart beating. Well, that

machine was left on, and the VCR-tape continued to run.

Well, the assistant surgeon and I went in and took our gowns off, and gloves and masks and things, and came back, and we were in our short-sleeve shirts, and we were standing at the door, kind of discussing if there was anything else we could have done and any other medicines we could have given, whatever, to have made this a success. And as we were standing there, it had been at least 20 minutes. I don't know this exact time sequence, but it was close to 20-25 minutes, that this man recorded no heartbeat, no blood pressure [gestures to indicate the monitoring machine's continuous paper readout], and the echo showing no movement of the heart, just sitting.

And all of a sudden, we looked up, and this surgical assistant had just finished closing him, and we saw some electrical activity. And pretty soon, the electrical activity turned into a heartbeat. Very slow, 30, 40-a-minute, and we thought, "Well, that's kind of an agonal thing," and we see that, occasionally, that the heart will continue to beat even though the patient can't generate a blood pressure or pump any blood. Well, pretty soon we look, and he's actually generating a pressure. Now, we are not doing anything; I mean, the machines are all shut off. And we'd stopped all the medicines, and all that.

So I started yelling, "Get anesthesia back in here!" and, "Get the nurses!" To make a very long story short, without putting him back on cardiopulmonary bypass or heart-lung machine and stuff, we started giving him some medicines, and anesthesia started giving him oxygen. And pretty soon he had a blood pressure of 80, and pretty soon a blood pressure of 100, and his heart rate was now up to a 100 a minute.

He recovered and had no neurologic deficit. And for the next 10 days [to] two weeks, all of us went in and were talking to him about what he experienced, if anything. And he talked about the bright light at the end of the tunnel, as I recall, and so on. But the thing that astounded me was that he described that operat-

ing room floating around and saying, "I saw you and Dr. Cattaneo standing in the doorway with your arms folded, talking. I saw the - I didn't know where the anesthesiologist was, but he came running back in. And I saw all of these Post-its [Post-it® notes] sitting on this TV screen. And what those were, were any call I got, the nurse would write down who called and the phone number and stick it on the monitor, and then the next Post-it would stick to that Post-it, and then I'd have a string of Post-its of phone calls I had to make. He described that. I mean, there is no way he could have described that before the operation, because I didn't have any calls, right?

MILLIGAN: And he's sitting, he's lying on the [gestures to indicate surgical table] - so he must have been floating?

RUDY: He was up there. He described the scene, things that there is no way he knew. I mean, he didn't wake up in the operating room and see all this. [Milligan: No.] I mean he was out [Milligan: Right], and was out for, I don't know, even a day or two while we recovered him in the intensive care unit. So what does that tell you? Was that his soul up there?

MILLIGAN: It's hard to know, but certainly brings that possibility into play.

RUDY: It always makes me very emotional.

After Milligan uploaded this video clip onto YouTube, in October, 2011, psychiatrist and NDE researcher Bruce Greyson brought the interview to the attention of researcher Jan Holden; suggested that she, as Editor of this Journal, send Rudy a letter inviting him to submit the case for publication as a case study; and gave her Rudy's address. She received no reply, and in subsequent correspondence with researcher Chris Carter, she learned that Rudy had died in April, 2012. Simultaneously, the case had aroused our own interest, and coauthor Titus Rivas had also tried to reach Rudy by email.

In the meantime, Milligan's entire interview with Rudy was uploaded onto the AAOSH-website (http://aaoshconnect.org/issue/march-20122013/article/aaosh-video-interviews). For this reason, coauthor Rivas approached Milligan to ask him for more details. Milligan sent the following reply:

> I met Dr. Rudy during an AAOSH meeting in Chicago in June, 2011, and had dinner with him where he told me about these experiences. I asked him to video them as I felt many people would be interested - I told him very few people would have the perspective he had, being a cardiac surgeon, etc. He reluctantly agreed, and we did the videos the next day. He was a wonderful and gracious man, and a pleasure to be with. Sadly, Dr. Rudy has passed away since we did the videos. (M. Milligan, personal communication, November 8, 2012)

Milligan also suggested two people who might have more information about the case, but when Rivas contacted them, unfortunately they did not.

In January 2013, a correspondent from the UK alerted co-author Smit to an online comment Roberto Amado-Cattaneo, M.D., had made to Milligan's YouTube clip. Amado-Cattaneo was the physician Rudy had referred to in his interview as his assistant cardiac surgeon, "Dr. Cattaneo." At the time of his comment, Amado-Cattaneo was connected to CardioWest Cardiothoracic Surgery in Great Falls, Montana. The comment, dated January 23, 2013, was:

> Everything that Dr. Lloyd Rudy explained in this video is absolutely true. I was there with him doing this surgery. The patient fully recovered and what he said to us after the surgery is what he experienced. - Dr. Roberto Amado-Cattaneo, cardiac surgeon, Great Falls, Montana.

On January 28, 2013, co-author Titus Rivas contacted AmadoCattaneo by email, and Amado-Cattaneo agreed to answer a few questions, also by email. Here are his replies:

> This case happened some time late 1990's early 2000's.
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> I do not know the patient's identity anymore. Neither do I think we can find out, unfortunately. It has been too long and I do not have any records of that case anymore. My role was that of assistant surgeon. I was in the case from beginning to end. I did witness the entire case and everything that my partner Dr. Rudy explained in the video. I do not have a rational scientific explanation to explain this phenomenon. I do know that this happened. This patient had close to 20 minutes or more of no life, no physiologic life, no heart beat, no blood pressure, no respiratory function whatsoever and then he came back to life and told us what you heard on the video. He recovered fully.
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> I do not think there was something wrong with the monitoring devices, The reason is that there are different types of monitors and they were left on. We could see a flat line, the monitor was on but not recording electrical activity in the heart. When he started coming back, we could see at first a slow beat that eventually evolved into something real closer to normal. The same with the ultrasound scan placed inside the esophagus, we saw no heart activity for the 20 minutes or

> so, machine still on, and then it started showing muscle movement, that is, contractility of the heart muscle that eventually turned into close to normal function, able to generate a blood pressure and life. The reason we saw him coming back is that fact, that the monitors were on and so we saw him regaining life, when this happened we restarted full support with drugs, oxygen etc.
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> This was not a hoax, no way, this was as real as it gets. We were absolutely shocked that he would come back after 20 or more minutes, we had pronounced him dead on the operating room table and told the wife that he had died.
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> I have seen people recover from profound and prolonged shock, but still having life, in this case there was no life. (R. Amado-Cattaneo, personal communication, January 28 and 30, 2013).

Subsequently, Rivas sent Amado-Cattaneo several additional questions suggested to him by Jan Holden and Bruce Greyson, about the veracity and normal explicability of the patient's statements and about the location of the monitor with Post-it messages respectively. AmadoCattaneo replied as follows:

> I do not believe he said anything that we questioned as being real, we thought all along his description was quite accurate regarding things he said he saw or heard. Patients' eyes are always shut during surgery, most of the time they are taped so they do not open since this can cause injury to the corneas. (R. Amado-Cattaneo, personal communication, February 13th 2013).
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> There are many non sterile equipment in an operating room including monitors. Monitors are close range so surgeons can "monitor different parameters through the case". The messages to Dr. Rudy I believe were taped to a monitor that sits close to the end of the operating table, up in the air, close enough for anybody to see what it is there, like the patient for example if he was looking at it. (R. Amado-Cattaneo, personal communication, February 15th 2013).

Our UK correspondent also had contacted Amado-Cattaneo who told him the incident took place at the Deaconess Hospital in Spokane, Washington.

Amado-Cattaneo's testimony is very valuable, as it explicitly confirms Rudy's account. The evidential value of this case is increased because of the component of the Post-it notes, which involved seemingly out-of-body visual perception of phenomena during documented continuous eyes-closed unconsciousness that was highly unlikely to have been deduced from sensory input such as hearing or from logical deduction. Neither Rudy nor Cattaneo indicated that the patient reported any erroneous content.

This case appears to belong to those most evidential cases of AVP in which perceptions during an NDE were confirmed as completely accurate by objective observers. We believe that the accumulation of such anecdotal evidence is making it increasingly difficult to dismiss this type of case out of hand.

Of course, this case would be complete if the identity of the patient could be established so that medical records could be examined, but unless Amado-Cattaneo recalls his name, such further investigation is not feasible. However, in our view, this imperfection only slightly reduces, but in no way negates, the case as serious evidence for AVP.

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