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The Gray Scale: A Diagnostic Tool for Assessing Deathbed Research Cases

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Abstract: Scientific research into the deathbed vision phenomena is hospice based. It studies frequent cases where dying persons have transcendent deathbed experiences. Some researchers argue this data points to the existence of the afterlife. However, we must adopt a posture of heuristic skepticism toward deathbed research. This paper proposes "The Gray Scale" as a detection tool that will assess whether a deathbed report may support the afterlife hypothesis or not.

1. Introduction

For the past seventy years, scientific research into the deathbed vision phenomena has been underway. While initially undertaken with the help of hospital doctors and nurses, more recently the research venue has moved to hospice staff. Those engaged in palliative care are focussed on treating physical symptoms. They also regularly encounter patients whose experiences are better described as "transcendent" rather than fully explainable by physical causes. These experiences include deathbed visions, or the reported encounter of supernatural beings as one nears their final earthly death. Some who have published their research on these reported experiences argue that it points to the afterlife. In this paper I contend we must adopt an epistemological posture of heuristic skepticism while assessing the available deathbed vision research. I will also present a diagnostic tool called "The Gray Scale." This tool aids in the assessment of deathbed research data by applying criteria that highlight evidence of afterlife-supportive deathbed phenomena. The Gray Scale helps one to detect whether a particular deathbed report may support the afterlife hypothesis.

2. Definitions

Deathbed Experiences (DBEs) are a cluster of afterlife-supportive experiences surrounding final earthly death. They include deathbed visions, terminal lucidity, crisis apparitions, shared death experiences, premonitions of death, and after death communications. There is not currently an agreed upon term covering this in the research. We choose to adopt the DBE term to refer to this cluster of experiences

in Afterlife Apologetics discussions. One can build a cumulative case for the afterlife by exploring all the phenomena within this cluster.

- **Deathbed Visions (DBVs)** are one type of DBE. DBVs include one or more of the following phenomena: reports of seeing / interacting with extraordinary, beautiful music or landscapes, deceased relatives, angels, Jesus, or other spiritual beings who join the dying in their final hours or minutes of earthly life.
- **The Afterlife Hypothesis (AH)** suggests that human life is not extinguished at the time of physical death.
- **Heuristic Skepticism (HS)** adopts a tentative and questioning approach to certain claims to knowledge.

3. Epistemological Assumptions and the Role of Skepticism in Deathbed Research

Epistemology has a vital role in philosophy. It explores how one can reasonably claim to know and believe something as true. It also assesses how we understand truthfulness, and it explores the nature of knowledge. Our epistemic assumptions undergird our scientific research. It is helpful, therefore, to lay out philosophical assumptions before progressing further with this paper's argument.

The epistemological claims made during deathbed research (DR) are generally constructed around a type of inference. Data is gathered from a carer's report, a researcher who investigated a report, or directly from the dying person themselves. An inference is then drawn from this data to arrive at an item of knowledge. DR typically makes inductive inferences. James Dew and Mark Foreman describe induction as a process of identifying particular observations that lead us towards probabilistic, general conclusions.[1] Commonly, we will also rely on a particular type of inductive inference; the abductive inference. Here, DR proposes the best explanation of an observed phenomenon.[2]

Because our inferences draw conclusions that may go beyond the research data, we must take care. Our inferences will inevitably be tainted in some way by the biases we hold about the world and our place in it. For example, if I hold an anti-supernatural bias, I am more likely to be comfortable drawing conclusions that challenge the afterlife hypothesis, and vice versa. One way of mitigating the negative influence of bias is by adopting a careful application of skepticism.

[1] James K. Dew Jr. and Mark W. Foreman, *How Do We Know? An Introduction to Epistemology,* (Downers Grove: IVP Academic, 2014), 70 – 71 summarised.

[2] Ibid., 73.

James Dew and Paul Gould define skepticism as an opposing tendency towards a claim to knowledge. For some ideas, one's confidence never rises to the level of certainty, and so we remain in an epistemic posture of questioning and debating the truth about these matters.[3] I propose adoption of careful skepticism in the assessment of DR. We must question the inferences we draw to mitigate any unhelpful effects of our worldview bias.

In this paper, I will adopt epistemic particularism with regards to knowledge claims. JP Moreland and William Lane Craig define the particularist as someone who thinks it is possible for persons to know some things simply and directly without needing a criterion for how they know them.[4] It is valid to claim to have direct knowledge in specific cases. For example, I can reasonably claim to know the thoughts of my own mind. Also, while my senses can fool me, it does not follow that my senses must always do so. Sense experience is an important aspect of scientific research, and there is always a logical possibility that unwitting deception has occurred. However, my senses are not necessarily misleading me as I read this paper, or as I assess the DR evidence. Our noetic equipment, and our senses, are viewed by the particularist as innocent until proven guilty. The logical possibility of error in the reception of sense data does not necessarily entail an epistemic possibility of error. As Moreland and Craig say, the latter requires an argument, and good reasons to think that I am mistaken in my observations.[5] This is a secondary role for careful scepticism. We remain open to reevaluating the DR data if such an argument is presented.

Because I assess DR data as an epistemic particularist, this allows me to build a case for arriving at knowledge claims. Moreland and Craig note this frees one from the need for absolute certainty in claims to knowledge.[6] Either I do not think this deathbed report meets the criteria for an afterlife-affirming DBE, or I think that it does. Crucially, I am not claiming certainty in my judgement either way. Rather, I am presenting a case for my knowledge claim, and I state this argument with a defined level of certainty. For example, if I am 60% sure a deathbed report could be afterlife affirming, I therefore have the right to identify and use my knowledge claims. But I remain open to the possibility that further data could come to light that will require reassessment of my confidence level in my knowledge claim.

I urge the adoption of careful skepticism in the assessment of DR data, and the inferences we draw from it. This is not, however, a type of Pyrrhonian skepticism that questions everything. Rather, I propose we adopt a posture

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[3] James K. Dew Jr and Paul M. Gould, *Philosophy A Christian Introduction*, (Grand Rapids: Baker Academic, 2019), 40.

[4] J P Moreland and William Lane Craig, *Philosophical Foundations for a Christian Worldview*, second edition, (Downers Grove: IVP Academic), 199.

[5] Ibid., 202.

[6] Ibid., 200.

described by Moreland and Craig as heuristic skepticism (HS).[7] The HS advocate agrees one can have justified true beliefs about subject matters. However, HS is a thoughtful method that aims to eliminate what we cannot claim to know and identify what we think we can. Our noetic capabilities are innocent until proven guilty, yet we are limited in our human capacities, and we are fallen and sinful beings. The Gettier problem has shown epistemologists that knowledge claims are necessarily always provisional. Consequently, we must question the validity of our inferences and check the accuracy of the data before us.

When assessing DR data, we must ask whether the data accurately reflect the actual conditions for the patient at the time. What did the patient actually claim to see or hear as they approached death? What medication was the patient receiving, and what effect do the medical professionals anticipate this will have on the patient? When we infer a conclusion about a particular deathbed experience, we are carefully asking, "Based on the methods used in the gathering and effecting of patient care, and based on what is recorded about the patient's experiences, how can we claim to know that X is the case?" This type of skepticism is not something to be rebutted; it is a "guiding method to help people understand knowledge."[8] While I may want to claim an experience as afterlife-affirming, my HS posture urges me to assess the conditions around the experience before I tentatively state that I know whether it is afterlife-affirming or not.

4. A Summary of Deathbed Research

In my assessment of the DR, and the creation of the Gray Scale, I have focussed on contemporary research studies documented in the following books and monographs:

- Sir William Barrett, *Deathbed Visions,* (The Aquarian Press: Wellingborough, 1986).

- Karlis Osis, *Deathbed Observations by Physicians and Nurses*. Parapsychological Monographs, No. 3 (New York: Parapsychology Foundation, 1961), https://catalog.hathitrust.org/Record/100023940

- Karlis Osis and Erlendur Haraldsson, *At the Hour of Death*, Revised edition (Guildford: White Crow Productions Ltd, 2012).

- Peter Fenwick and Elizabeth Fenwick, *The Art of Dying*, (London: Bloomsbury, 2008).

[7] Ibid., 188.
[8] Ibid.

- Bigelow Institute, "Experiences of the Dying: Evidence of Survival of Human Consciousness," accessed August 23rd, 2024, https://www.bigelowinstitute.org/wp-content/uploads/2022/10/kerr-experiences-dying.pdf

- Dr Christopher Kerr and Carine Mardorossian, *Death is But a Dream*, (London: Quercus, 2020).

- Cheryl L. Nosek, Christopher W. Kerr, et al., "End-of-Life Dreams and Visions: A Qualitative Perspective From Hospice Patients," *American Journal of Hospice and Palliative Medicine* 32, no. 3 (May, 2015), accessed August 23rd, 2024, https://doi.org/10.1177/1049909113517291

- Elisabeth Kubler-Ross, *The Tunnel and the Light: Essential Insights on Living and Dying*, (New York: Da Capo Press, 1999)

- M. Renz, M. Schuett Mao, et al, "Spiritual Experiences of Transcendence in Patients With Advanced Cancer," *American Journal of Hospice & Palliative Medicine* 32, no. 2 (2015), accessed August 23rd, 2024, https://doi.org/10.1177/1049909113512201

4.1 Relationship Between Deathbed Research and the Afterlife Hypothesis

Early DR was motivated to confirm the afterlife hypothesis. Karlis Osis claims to have scientifically corroborated Sir William Barrett's eyewitness deathbed reports supporting the afterlife hypothesis.[9] As time has passed, the DR focus has moved from assessing the possibility of the afterlife, to understanding the process of death and drawing conclusions based on these observations. For example, Peter Fenwick observes the comforting effect of DBEs and asks whether they might help people prepare for the death that awaits them.[10] Christopher Kerr has amassed a volume of valuable DR material. While other researchers focussed upon reports by the carers and families of the dying, Kerr's team interviewed the dying and asked them about their experiences in the weeks leading up to death. Again, Kerr's focus has been to raise awareness about the process of dying, and confer value to it in the lives of his patients. In his book, rather than exclusively viewing death as a prelude to the afterlife, he focuses on it as a valuable human experience in its own right. Thus in his book, Kerr wants to avoid speculating on what he

[9] Karlis Osis, *Deathbed Observations by Physicians and Nurses*. Parapsychological Monographs, No. 3 (New York: Parapsychology Foundation, 1961), 89, accessed August 23rd, 2024, https://catalog.hathitrust.org/Record/100023940

[10] Peter Fenwick and Elizabeth Fenwick, *The Art of Dying*, (London: Bloomsbury, 208), 13.

cannot know, whether there is an afterlife, and focus instead on what he can study in the death of his patients.[11]

The purpose of the Gray Scale is to return some balance back into the DR field by calling researchers to again consider the possibility of and evidence for the afterlife. We can study and value the process of dying and its effects on everyone involved. Yet we do not have to do so at the expense of considering afterlife related issues as well. We can do both.

I value Kerr's honesty and his humane and caring approach to the dying. I also understand his insistence that we must focus on what we can study, and not speculate on what we cannot. Yet surely the heuristic skeptic must ask whether it is necessary to stop there. Why would it be wrong to seek to draw further inferences based on Kerr's own data that relate to the possibility of an afterlife? I agree the religious believer must not permit worldview bias to falsely direct their inferences to claiming support for the afterlife hypothesis where no such support exists. But the opposite is also true. Someone who believes there is no afterlife must also not allow bias to prevent them from drawing tentative inferences about the possibility of an afterlife based on the DR data. I suggest we can meet Kerr's humane requirements and also engage in Afterlife Apologetics. We can value the experience of death and consider what this experience may tell us about the afterlife that we can infer from it.

Further, a renewed openness to afterlife inferences may further contribute to the care that medical professionals give to the dying. Were a nurse to believe her patient was interacting with deceased relatives in an afterlife, thereby accepting their claims at face value, this would achieve the following. First, the nurse would be accepting and validating the patient's experience. Second, this would help the nurse better empathize with their patient.

5. The Gray Scale

5.1 Introduction

DR data is typically presented as a series of case studies, describing the deaths of patients, and their associated experiences. The Gray Scale is a question-based diagnostic tool that is applied to DR case studies. It draws a tentative distinction between two general types of deathbed experience; afterlife-affirming cases, and non-afterlife affirming cases.

5.2 Method

The Gray Scale differentiates types of DBE through the application of a series of questions ordered into two separate domains. The questions are

[11] Dr Christopher Kerr and Carine Mardorossian, *Death is But a Dream*, kindle edition, (London: Quercus, 2020), loc 2736.

assembled from current DR results. The first domain covers patient experiences caused by internal physical and psychological factors. The second domain covers experiences caused by external factors received by the patient.

5.3 Procedure

The Gray Scale tool produces two indices. Each index scores a domain of patient experience. External factors result in the External Vision Index (EVI). This number weighs the Gray Scale result towards an afterlife-affirming score. Internal factors result in the Internal Vision Index (IVI). This number weighs the Gray Scale result towards a non-afterlife affirming score. The balance between the internal and external domains is expressed thus:

EVI : IVI

Bear in mind the epistemological commitments I described earlier. We are making a claim to know the status of this deathbed experience in a tentative way. We are not absolutely certain about our conclusion. Rather, we are posing an argument that is informed by the research and remain open to further data that could alter our current conclusions about this particular case.

5.4 Data Analysis

Some case studies will generate an IVI score that is higher than the corresponding EVI score. This suggests that this case study would probably not be afterlife-affirming. A Gray Scale result with an EVI score higher than its IVI score argues for an afterlife affirming case. Further, a case that results in both high EVI and IVI indices together at the same time would also argue for an afterlife affirming case study. This is because we recognize that the process of death is complex for many physical and psychological reasons. We are using this tool to understand whether a DBE might be occurring for the patient amidst the internal changes occurring before death.

Kerr observes that deathbed phenomena increase in his patients as death approaches.[12] It would be expected therefore that the Gray Scale might be applied multiple times to a patient's changing situation. The EVI score may increase through multiple applications of the tool up to the point of the patient's death.

5.5 Questionnaire: Gray Scale Stage One

We begin by posing six questions to assess our initial level of skepticism toward a case study before us. If the data came from the dying patient themselves, we would apply these questions to the patient. If we only have a second-hand

[12] Kerr and Mardorossian, *Death is But a Dream*, loc 628.

report from a family member, or care staff, then we would apply the questions to both the patient and the source of the report.

If we receive a "yes" to one or more of the stage one questions, this sets a high level of skepticism toward this case and it will probably not be necessary to continue to stage two of the Gray Scale. Steve Miller notes the first stage is important in avoiding false stage two reporting. If the patient has reasons to deceive the researcher, then we do not need to consider their case study any further.[13] The stage one questions allow us to select an appropriate subject for Gray Scale analysis. We need a "No" to all six questions to move to the next stage.

Question 1: Is there a history of mental illness in the patient or the reporter?

Question 2: Is there a history of exaggeration or lying in the patient or the reporter?

Question 3: Is there a clear motive for the patient, or the reporter, to lie about the claimed deathbed experience?

Question 4: Is there evidence that the patient has taken drugs that could either have caused the experience, or tainted the experience in some way?

Question 5: Is there a reason to question the source of the report? For example, was it received third-hand, or was it posted anonymously to an online database?

Question 6: Is this patient not actually close to death?

5.6 Questionnaire: Gray Scale Stage Two

The goal of stage two is to generate both an EVI and an IVI score by answering a series of questions. Nineteen EVI questions and eleven IVI questions are listed in the table below. Each question results in a point scored answer. A "yes" response to a question will result in a score of 1. A "no" response to a question will result in a score of 0. Each index is calculated as a total of all the scores received once all questions are answered. The final EVI index value is the total of all EVI scores. The final IVI index value is the total of all IVI scores.

External Vision Index (EVI) Questions	Internal Vision Index (IVI) Questions
EVI1 – Is the patient conscious and alert to their surroundings?	IVI1 – Did the patient have a vision involving living persons, or events focussed on this world and its concerns?

[13] J Steve Miller suggested looking for obvious red flags like this during our email discussion about The Gray Scale, September 8th, 2022.

EVI2 – Was a measurable change in mood detected prior to the patient's death? The change might be positive or negative.	IVI2 – Does the purpose of the vision seem unclear to the patient, their carers, or the wider family members?
EVI3 – Did the patient claim to have a conscious vision involving the visit of dead relatives or spiritual beings (angels, Jesus, or other)?	IVI3 – Does the vision involve the reliving of memories of past events and the expression of emotions related to them?
EVI4 – Did the patient claim to have a realer-than-real vision of dead relatives or spiritual beings while unconscious?	IVI4 – Does the vision seem to result in the patient's feeling of completeness before death?
EVI5 – Did the patient claim to engage in discussion or debate with individuals in the vision?	IVI5 – Does the patient claim to reunite with still living or estranged friends or relatives in their vision?
EVI6 – Did the patient claim to receive new information during their vision that can be verified?	IVI6 – Is the patient unconscious before death, so cannot discuss their vision?
EVI7 – Did the people seen in the vision show evidence of having a will of their own apart from the patient's will or knowledge or intentions?	IVI7 – Does the vision have no positive or negative impact on the patient's mood?
EVI8 – Do medical staff not expect the patient to die?	IVI8 – Does the patient volunteer information about the vision freely, with no embarrassment?
EVI9 – Is the patient not suffering a brain-related illness?	IVI9 – Is the patient sedated, or have they been diagnosed with a pathological brain condition?
EVI10 – Does the patient show unexpected correct knowledge about their time of death?	IVI10 – Do medical professionals expect the patient to die soon?
EVI11 – Was the content of the patient's vision shared with another person or persons in the room while it occurred?	IVI11 – Was the patient eagerly expecting to experience such a vision?
EVI12 – Did the patient express some embarrassment or reticence about sharing the contents of their vision with their carers, especially the doctor?	
EVI13 – Did the medical professionals state that the vision was probably not due to medication?	

EVI14 – Was the content of the vision clear and crisp, not vague or dream-like?	
EVI15 – Did the patient lack the hallmarks of hallucination during their vision (confusion, fear, disordered thinking)?	
EVI16 – Was the patient conscious leading up to death, and talking clearly about the content of the vision?	
EVI17 – Did the patient say the vision prepared them for going on a trip or a journey? Did he or she seem to be mentally preparing for this journey?	
EVI18 – Was the vision and its content unexpected by the patient?	
EVI19 – Was some of the visionary content contrary to cultural and personal expectations, yet consistent with other reported DBVs?	

5.7 Discussion

IVI1:

Kerr's research contains patients who approach death feeling worried about the important tasks they will be unable to complete after their death. For example, he describes a young mother who is rightfully worried about paying her household bills, and also her children's wellbeing.[14] These worries seem natural, but not afterlife affirming.

IVI3 and IVI4:

Kerr notes his hospice patients often draw subjective assessments of traumatic life experiences from a distance. For example, John was a decorated war veteran who relived D-Day before his death. He had terrifying nightmares and regretted his failure to save many lives. Yet immediately prior to death, John had become more comfortable. He began dreaming of fallen comrades accepting him and coming to take him away. His perceived failure was gone, and his terror gave way to

[14] Cheryl L. Nosek et al., "End-of-Life Dreams and Visions: A Qualitative Perspective From Hospice Patients," *American Journal of Hospice and Palliative Medicine*® 32, no. 3 (May 1, 2015): 269–74, https://doi.org/10.1177/1049909113517291

completeness.[15] This seems to describe a natural process of coming to terms with the past.

IVI8:
Visions that are freely shared with caring staff are more likely to be explained naturalistically. Visions that are afterlife-affirming will challenge the presuppositions of naturalism and may be harder for the patient to share with medical staff. Fenwick observes a conspiracy of silence amongst medical staff around DBVs. They are often not taken seriously, but are dismissed as drug related hallucinations, even if the patient is alert and lucid. It is a prevailing anti-supernaturalism in medicine that leads to patient reticence.[16]

IVI11:
We are trying to determine whether the patient's expectations could be informing their hallucinatory, near-death state. For example, were they anticipating a reunion with their dead spouse? If so, this expectation may have contributed to the content of their hallucination.

EVI2:
There are countless cases of pre-death elation throughout DR. For example, a dying sixteen-year-old child became conscious. She was alert but faced the end of a short and unfulfilled life. Yet in the moments before her death, she was heard to declare with exultation in her voice, "I see him. I see him. I am coming." She died immediately afterwards.[17] Osis and Haraldsson interpret the sudden raising of mood as showing the patient has received a glimpse into the life that is to come.

EVI3:
All DR give case studies involving patients who experience visions while both awake and asleep. Waking visions often involve the visit of deceased relatives or spiritual beings who come to visit with the patient and appear to be visible to them in their natural surroundings.

EVI5:
If a vision involves the visit of a real immaterial, deceased or spiritual being, then this visitor would demonstrate distinct intentions or goals that may challenge the intentions of the dying patient. This is afterlife affirming because it suggests the vision is not caused by the patient's own hopes and wishes. For example, Chris

[15] Kerr and Mardorossian, *Death is But a Dream*, loc 733 - 776.

[16] Fenwick and Fenwick, *The Art of Dying*, 41-43, summarised.

[17] Karlis Osis and Erlendur Haraldsson, *At the Hour of Death*, revised edition, (Guildford: White Crow Books, 2012), 37.

Alcock's father had a disagreement with his visitors about the time of his death. He wanted to stay until Chris had arrived to say goodbye.[18]

EVI6:
Sometimes the patient will learn about the death of a family member during their vision. This knowledge is not the result of a conversation with a presently living individual, and so suggests information has been received from a supernatural source.[19]

EVI8:
A DBV that occurs for a person who is not expected to die may be afterlife-affirming. It suggests the visitor in the vision may know something the patient or his physician does not know through naturalistic means. An example might be the diagnosis of an incurable medical condition. A patient who does not anticipate immanent death is unlikely to prepare for death by projecting their hopes and desires onto a hallucination. If one expects to recover yet has a DBV and then suddenly and unexpectedly dies, this suggests the vision source may be external. The appearance of the vision is at odds with the expectations of the patient and his carers.

EVI10:
Osis and Haraldsson report the case of a young child who told her parents and physician that God was calling, and she was going to die. The doctor saw no reason for concern, yet she died the following day. This could be an instance of death by self-suggestion. If so, how might this suggestion have arisen in such a young patient?[20] An alternative possible explanation is that the information was received from an external, supernatural source.

EVI15:
Palliative care staff say that drug induced visions are of a different quality to DBVs in their patients. Thus, we can identify a hallucinating person by listening to what they are saying, and by looking into their eyes. Hallucinating persons show genuine confusion and fear. DBVs, on the other hand, typically bring comfort and assurance. Fenwick records a case where a patient experienced both a hallucination and a DBV of his mother at the same time. He was frightened by his hallucination, but comforted by his mother's presence and knew everything would be alright. His language use was completely different when he described his DBV.[21]

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[18] Fenwick and Fenwick, *The Art of Dying*, 27.

[19] Elisabeth Kubler-Ross, *The Tunnel and the Light: Essential Insights on Living and Dying* (New York: Da Capo Press, 1999), 87.

[20] Osis and Haraldsson, *At the Hour of Death*, 39.

[21] Fenwick and Fenwick, *The Art of Dying*, 81.

EVI18:
If the patient was not expecting to experience a vision of this kind, then we are unlikely to be able to view patient expectations as informing this vision, or hallucination.

EVI19:
Steve Miller suggests a DBV example that challenges cultural or personal expectations is Doctor William Barrett's discussion of dying children who claimed they saw angels without wings.[22] Traditional religious upbringing, and children's story books, would result in a mental image of a winged angel. Despite their expectations, and contrary to their instruction, these children reported that the angelic beings they saw lacked wings. Miller asks how these children could even identify the beings as angels, suggesting it would be more likely they would describe them as people.[23] This experience challenged both cultural and personal expectation in the child, suggesting that the information about the angel's identity was not from the child themselves. It is therefore possible that the information came from the other side.

6. Example Gray Scale Analysis: Angus Shaw's DBE

Angus Shaw, my grandfather, died of heart failure in July 1996. This account is given by his daughter, and my mother, May Gray. She has summarised her conversation with her father many times since it occurred, and she has always carefully reported the events and the words Angus used. While the order of events is sometimes reversed in her report, the particular words she uses are always the same.

Angus was not particularly religious. He was a loving grandparent, and accomplished musician and teacher. He was open to God's existence, but struggled to see how he could have a relationship with such a being. He had a history of heart problems. Angus was hospitalized on Friday 19th July, and by Monday his physician announced he was in the final stages of heart failure. Angus was slumped in bed, and fearful of impending death. He was prescribed oxygen and minimal pain medication. His daughter May returned to visit on Wednesday and saw a marked difference in him. He sat upright and alert, and his anxiety was replaced by excitement and urgency. "I've had a visit," he beamed. He then spoke a word that May, a Christian, had never heard him use before. "It was the Lord." His visitor

[22] J. Steve Miller, "Deathbed Experiences as Evidence for the Afterlife A Multicultural Examination of the Literature (How Scholarly Studies of Death-Related Phenomena Are Challenging Materialistic Reductionism)," (PhD diss. Columbia International University, 2019), 252.

[23] Ibid., 253.

informed Angus that his family had been praying for him. Angus went on: "The Lord said, if you are going to do something about this, you will need to do it soon." May asked, "What did you say to him dad?" He looked at her over the rim of his glasses. "What do you think I said to him?" Their conversation was disturbed by medical staff, but Angus patted her hand later that day. "Now I know what you have been trying to tell me all these years. I will be fine." His confident expression assured May that Angus had finally found the Lord Jesus. For the next 48 hours he was a different person. He was ill, but anxiety had been replaced by peace and assurance. On Thursday he discussed strategies for dealing with his impending absence, and the practical challenges this presented for my grandmother Mollie. Angus died on Friday morning.

The Gray Scale Stage One questions all return a "no." The answer to question 4 is a no because, given he was dying of heart failure, he was simply on minimal pain medication and oxygen. Question 5's answer is no because the report comes first hand from his daughter May.

The Stage Two IVI index returns a score of 2. We return a "yes" to IVI8. Angus described the contents of his vision enthusiastically to his family. We do not believe he informed the medical staff of his vision. IVI10 returns a "yes" because he was diagnosed as being in the final stage of heart failure.

The Stage Two EVI index returns a score of 10. The account of the DBV returns "yes" to EVI1 and EVI2. May was not informed about Angus' conscious state, so either EVI3 or EVI4 return "yes." EVI5 and EVI7 return "yes." In fact, "the Lord" challenged Angus on his unbelief. EVI9 is a "yes," because he had heart problems. EVI14 to EVI16 are "yes." Angus was consciously discussing a clear and vivid vision. EVI18 is a "yes." Angus was not a particularly religious man, so was not likely to anticipate meeting Jesus at the end of life.

A Gray Scale result of 10:2 means that Angus Shaw's account qualifies as an afterlife-affirming DBE.

7. Conclusion

In this paper, I have urged a posture of heuristic skepticism while assessing DR and seeking to use it to draw inferences about the existence of an afterlife for human persons. I have presented an easily administered diagnostic tool, The Gray Scale, which draws a distinction between cases that may allow us to infer the existence of an afterlife, and those that may not. I hope this tool will enable us to think critically about the subject of DBVs and their importance in the task of Afterlife Apologetics.

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