

Deathbed dreams and visions: what Christopher Kerr's research actually shows

A deep dive into the Diary of a CEO interview, the hospice studies behind it, their results and limitations—and an accessible library of the original research.

Managing Expectations research edition · October 19, 2026

The finding worth taking seriously

Many dying patients describe vivid dreams or waking visions that feel real, often involve people they have loved and lost, and can bring comfort. Christopher Kerr and colleagues have published research documenting these experiences and examining their meaning for patients and bereaved families. That is a genuine clinical research programme—not simply an internet ghost story.

The boundary matters just as much: reports of an experience are not independent verification that a deceased person was present. These studies do not establish consciousness surviving irreversible death. Nor do they guarantee that everyone dies peacefully, has visions, resolves trauma or grieves more easily. We can respect the experience without overstating its explanation.

Care note: this is an evidence review, not medical advice or a diagnosis. New confusion, unusual drowsiness, agitation, pain, breathlessness or distress should be discussed promptly with the treating or hospice team. Do not alter medicines, hydration or treatment on the strength of an interview.

The source interview

[Watch the complete original interview](#) · The Diary Of A CEO · published October 19, 2026. The full English auto-caption track and description were reviewed; advertising segments were separated from the substantive discussion. Captions can misrender names and individual words, so bibliographic identities were checked against research sources.

At 03:23, Steven Bartlett says he has “I think 15 research papers” in front of him. He does not supply a complete numbered bibliography. Our library therefore identifies its scope explicitly: the publications in Kerr's official research page, the ELDV section of Hospice Buffalo's research page and its 2026 toolkit, supplemented by identifiable studies and contextual sources discussed in the interview. It is not represented as a verified reconstruction of every sheet on Bartlett's desk or as Kerr's complete career bibliography.

1. What is an end-of-life dream or vision?

In this research, an end-of-life dream or vision—ELDV—is a reported experience during the dying process. A dream occurs during sleep; a vision is reported while awake. Content may include deceased or living relatives, friends, animals, travel, familiar places, religious figures or unresolved experiences. The researchers are interested in frequency, content, subjective realism, comfort and meaning.

These are **experiences before death**. They should not be merged with near-death experiences recalled after a medical crisis and resuscitation, terminal lucidity, or dreams experienced by otherwise healthy bereaved people. Those are related but distinct questions with different populations and methods. Dreaming of a deceased relative is not, by itself, evidence that someone is about to die.

The hospice team's own [2026 toolkit](#) explicitly says its work does not establish an afterlife and excludes paranormal experiences and sudden deaths from the toolkit's substantive scope. It also asks caregivers not to impose their own beliefs on a patient's interpretation.

2. “Nearly 90%”: a real finding, but not a universal rate

The pilot research is a repeated-interview study of selected hospice patients—not a representative census of everyone who dies. Its published final sample is **59 patients**. The official programme reports **88.1%** experiencing at least one ELDV. This supports “common in this studied hospice group,” not “90% of all human beings see deceased relatives.” The experience category is broader than seeing the dead.

At 02:42, Kerr estimates that he has interviewed about 1,500 people by this point. That cumulative interview claim must not be substituted for the enrollment of the 2014 study or treated as one published 1,500-person trial. Likewise, repeated interviews, individual dreams and unique patients are different counting units.

The reported increase in comforting experiences featuring the deceased near death is an association within the research. It is not a validated countdown or clinical prediction tool. Patients who could consent, communicate and complete interviews are not interchangeable with people who were too ill, delirious, unconscious or cognitively impaired to participate.

3. “It felt real” is important—but answers a different question

The official research page reports that **99%** described their experiences as seeming or feeling real. The interview sometimes uses absolute language such as “always” when describing realism. The defensible finding is that a very high proportion reported strong subjective realism—not that every account was objectively verified.

Feeling an experience intensely can make it emotionally consequential. It does not distinguish, on its own, among memory, dreaming, perception, neurological changes or a spiritual interpretation. A questionnaire about realism is not a measurement of an independently present deceased person.

Similarly, the study finding that experiences involving deceased loved ones were especially comforting does not show that all dreams were pleasant. The official website reports both comforting and distressing experiences; the interview itself discusses painful dreams and patients who struggled. Differences among headline distress percentages in the interview, website and toolkit should not be averaged into a single “true rate” without matching their denominators and definitions.

4. Delirium: neither dismiss everything nor overlook illness

At 15:58, Kerr explains that his studies screened participants for confusion. This is a real methodological strength: the researchers were not simply collecting every hallucination in a severely confused inpatient population and calling it an ELDV.

But screening a research sample does not provide a home diagnostic rule. A comforting, coherent account does not automatically exclude delirium, medication effects or another medical issue. Delirium can fluctuate and can be **hypoactive**—quiet, withdrawn or unusually sleepy—not just agitated and frightened. Clinical assessment matters, especially when a person's attention or alertness changes.

A 2026 international clinician survey adds a useful reality check: 247 responses were analyzed, 18.6% reported never encountering patient reports of ELDVs, and only 9.3% reported relevant training. Clinicians identified missing protocols and standardized criteria as important challenges. This is a self-selected professional survey—not a patient-prevalence estimate or evidence that clinicians can always distinguish the experiences effortlessly.

The sensible middle position is to listen without ridicule, ask how the experience feels, and involve the care team when there is new confusion or distress. The patient does not have to defend a spiritual belief to receive compassionate symptom care.

5. Growth and bereavement: meaningful associations, not proven cures

The posttraumatic-growth studies explore positive psychological changes in people facing serious adversity. They provide a more nuanced picture than the assumption that physical deterioration means there can be no emotional or spiritual development. They do not show that visions cause growth, reverse disease, or guarantee resolution of lifelong trauma.

A later 2025 comparison of self-transcendence is especially important: among 72 hospice patients—35 reporting ELDVs and 37 not reporting them—there was **no statistically significant difference** on the self-transcendence measure ($p = 0.310$). This does not prove equivalence, but it means that this study did not demonstrate greater self-transcendence in the ELDV group. Positive narratives should not erase this null finding.

The caregiver work similarly asks whether a dying person's experiences, and the family's interpretation of them, relate to bereavement. The library distinguishes the earlier caregiver survey, the later attitudes/focus-group study and the separate study of growth during bereavement. A figure such as "750 families" is not evidence that 750 people all had their grief successfully treated.

These are largely observational reports, often retrospective. Selection, recall, pre-existing beliefs, family relationships and the quality of care can influence both the interpretation of a dream and the reported grief outcome. Positive associations are valuable clinical signals, but not randomized evidence that inducing visions improves bereavement.

No family has failed because a death was difficult or no comforting vision was reported. Grief has no single correct trajectory. The filmed examples in the interview are illustrative personal stories, not a complete account of all patients' outcomes.

6. Children: moving accounts, limited generalizability

The interview's closing section describes children's experiences. The directly relevant published pediatric paper is explicitly a **case study**. A detailed account can reveal clinically important possibilities, but it cannot establish how often children have ELDVs or prove that children universally accept death without fear.

Children differ in developmental understanding, illness, communication, family context and distress. Statements such as "children die differently" are best read as the clinician's observations, not a rule that eliminates the need for skilled pediatric palliative care. Families should not be encouraged to hide information, discontinue symptom relief or expect a particular spiritual experience.

7. Does this prove an afterlife? Kerr's own qualification matters

At approximately 08:04, Kerr says he does not know what the experience means and would not be so bold as to say it speaks to an afterlife. Later, around 13:40 and 48:11, he expresses personal spiritual beliefs and discusses continuing or collective consciousness.

Those statements belong in separate categories: **documented patient reports**, **scientific interpretation** and **personal belief**. The interview contains all three. A hypothesis about consciousness does not become a result of a hospice interview study merely because a researcher finds it persuasive. Equally, uncertainty about mechanism does not make the patient's experience worthless or settle religious belief against the patient.

The practical conclusion is narrower and stronger: these experiences can be important to the people reporting them and deserve sensitive clinical attention.

8. What patients prioritize—and what rankings cannot prove

The identifiable [patient-goals study](#) compared **80 hospice patients with 176 medical students** using an 11-item survey. Students ranked seven goals differently from patients, including burden on family, time with loved ones, spiritual peace, home death, meaningfulness, longevity and resolving conflicts. That supports asking patients directly rather than assuming professionals already understand their wishes.

A ranking is relative to the choices offered. A low position for resolving conflicts is not evidence that nobody has regrets, and concern about being a burden is not a judgment that a person actually is a burden. The published abstract verifies the sample and differences; this review does not claim to have independently audited every rank in the interview's displayed chart. The full publisher record is linked in the library.

Other qualitative work records personal growth, relationships, spirituality, vocational fulfillment and regret. These studies explore experiences; they do not supply a universal prescription for what makes a life worthwhile. The popular regrets account attributed to Bronnie Ware is also not a representative population survey.

The interview's wording that someone "can't die" without sleep should not be interpreted as a literal biological rule or a reason to force sedation. Reduced intake can accompany dying, but swallowing safety, hydration, mouth care and medication decisions require individual assessment. Home-care preferences vary, and dying at home is not always feasible or safest. Approximate US home-death and hospice-stay figures in the conversation are not presented here as verified current Canadian statistics.

9. Independent research: why the denominators matter

A [systematic integrative review by Hession and colleagues](#)—published online in 2022 and in a 2023 journal issue—identified 22 papers representing 18 studies. Its pooled estimates differed markedly by who was asked: **77% of patients** (95% confidence interval 69–84%; patient denominator 119) versus **32% of bereaved family respondents** (21–44%; denominator 2,444). Eighty percent of healthcare professionals in a separate pooled group reported witnessing or hearing about an ELDV in the previous five years. That is not an 80% patient prevalence.

The review supports taking ELDVs seriously, while showing how a headline percentage depends on the question, definition, setting, time window and respondent. It is not an independent experiment showing that spirits visit patients. Nor are 22 papers necessarily 22 independent groups of patients.

A [large Japanese bereaved-family survey](#) provides another perspective. Of 2,221 analyzed responses, 463 reported deathbed visions—21%, with a 95% confidence interval of 19–23%. Good-death scores did not significantly differ between those reporting visions and those not reporting them. This is not a direct contradiction of the hospice pilot:

retrospective family reports and narrower deathbed-vision definitions differ from repeated interviews with patients about dreams and visions. It does challenge any universal “almost everyone, always beneficial” framing.

One particularly important result is easy to miss in the positive narrative: in the [228-caregiver study](#), validated Core Bereavement Items scores did **not** differ significantly between caregivers whose loved ones reported ELDVs and the other caregivers. Comfort and meaning were described, but that is not equivalent to a demonstrated reduction in overall grief severity.

A [Brazilian case report](#) also describes meaningful ELDV-like experiences co-occurring with delirium. One case cannot establish prevalence or a definitive classification, but it reinforces the clinical warning: pleasant content is not a reliable test for absence of delirium.

10. Dying can be less frightening than expected—not universally painless

The interview and its promotional description emphasize peaceful dying. That can offer real reassurance, but it should not become a promise. The [US National Cancer Institute’s evidence summary](#) reports pain in 30–75% of patients in the last days of life in the cited literature, while also explaining that most patients can obtain relief and average pain intensity often decreases near death. Its context is principally advanced cancer; those estimates are not universal rates for every disease or care setting.

The same clinical resource recognizes comforting encounters with deceased loved ones as a poorly understood phenomenon that appears distinct from delirium. It also describes terminal delirium as common and often hypoactive. Compassionate listening and medical symptom assessment are complementary, not competing, responses.

Discussion of accepting death must not be translated into refusing beneficial treatment, withholding analgesia or stopping prescribed medicines without clinical advice. Palliative care supports comfort and goals of care; it is not a judgment that a person has stopped mattering. Ask the treating team what can be relieved, what changes need attention and what the person wants.

11. Other claims in the interview: the actual papers and limits

Genetics and lifespan, around 43:00

The identifiable [Science paper by Shenhar and colleagues](#) estimates approximately 55% heritability of intrinsic lifespan variation after modelling confounding from extrinsic mortality and age cutoffs. It is a modelling and twin-data reanalysis, not a longevity-treatment trial. “55% heritability” does not mean 55% of your personal lifespan is fixed by genes, and does not show that prevention or lifestyle is pointless. Its final PDF records a February 20, 2026 correction to a funding grant number, not a change to the results.

Healthspan versus lifespan, around 42:00

The interview’s roughly 11-year US gap is not fully identified by a spoken citation. A relevant [2024 JAMA Network Open analysis](#) of 183 WHO member states reports a US gap of 10.9 years in 2000 and 12.4 years in 2019. It is included as a **contextual companion, not a confirmed exact interview citation**. The gap is population life expectancy minus health-adjusted life expectancy, which uses disability weights. It is not a forecast that every individual spends their final 12.4 consecutive years seriously ill. The data end in 2019; the publication date does not make them 2026 observations.

Psychedelics, around 50:53

Two relevant randomized crossover trials—[Griffiths and colleagues, 51 participants](#), and [Ross and colleagues, 29 participants](#)—reported improvements in depression or anxiety among selected patients with life-threatening cancer receiving psilocybin with structured professional support. These are contextual papers, not titles expressly named in the interview. Small samples, difficult blinding, expectancy and crossover limit interpretation, especially at longer follow-up. They do not establish that everyone loses fear, that a peaceful death is guaranteed, or that the intervention proves an afterlife. Transient distress and physiological adverse effects occurred; the findings do not support unsupervised use.

“53%” and dreams of deceased relatives, around 57:50

The relevant [Pew Research Center survey](#) found 53% of US adults said a deceased family member had visited them in a dream or in any other form. That is broader than “53% dream of dead relatives.” The separate figure for dreams in the past 12 months was 34%. These are self-reports in a general-adult survey, not dying-patient data or independent verification of contact with the dead.

Statements we could not assign to a specific published result

The interview mentions recently completed work about suffering and expectations without enough identifying information to map it confidently to a publication. Its cumulative interview totals, selected patient histories, observations about regrets and comments about longevity culture should not all be presented as individually verified study findings. No paper has been invented to fill a gap.

12. What families can take from this

- **Listen first.** “Would you like to tell me about it?” and “Was it comforting or upsetting?” make space for the person without imposing an explanation.
- **Support meaning without asserting proof.** It is possible to respect a spiritual interpretation without claiming science has established it.
- **Tell the care team about new confusion, fluctuating alertness, agitation or distress.** These may need clinical assessment even when an experience sounds coherent or comforting.
- **Ask about the person’s own priorities.** Relationships and burden concerns often matter; do not assume every patient ranks them the same way.
- **Do not expect a perfect ending.** Absence of visions, unresolved feelings or a difficult death is not a failure by the patient or family.

This article is research reporting, not a diagnosis or treatment plan. For symptoms or medication decisions, use the patient’s clinical team. For immediate danger or a medical emergency, contact local emergency services.

13. Read the papers and the results

[Open the complete research library: individual results, limitations and original-paper access](#)

What “all the papers” means in this library

A bounded catalogue of the ELDV publications and related adjuncts on Christopher Kerr’s research page, the ELDV section of Hospice Buffalo’s research page, and the publications in its 2026 toolkit, plus explicitly labelled independent and interview-side-topic sources. Books, chapters, toolkit, survey report and clinical guidance are distinguished from journal papers.

33 catalogued documents; 27 journal papers; 4 unchanged original PDFs hosted with verified reuse permission.

The host says he has about 15 papers but provides no numbered bibliography, so this is not a certified inventory of every sheet on his desk or all of Kerr’s career publications. We could not identify the recently completed suffering-expectations study confidently. Several papers are available only through publisher access; complete PDFs could not be obtained or cleared for redistribution for every record. Original-copy access and summary-only/abstract-only limits are labelled individually.

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Methods and disclosure

The complete English auto-caption track, description and chapters of the 83-minute interview were captured and reviewed. Advertisements were separated from substantive claims. Bibliographic records were cross-checked against PubMed/Europe PMC, Crossref, publisher records and institutional sources; abstracts and accessible full texts were distinguished. Sample sizes, respondent types, overlapping research streams and null findings were checked. Available PubMed editorial-notice metadata and the Science PDF correction were reviewed; this is not a guarantee that every later notice has been captured. Only article-specific CC BY permissions justified local unchanged PDF copies. No full interview transcript or paywalled book/article text is republished.

Research and publication: October 19, 2026. No claim is made to have reproduced the studies or obtained unpublished patient data. No patient records, full interview transcript or unlicensed journal PDFs are republished.

Selected sources are cited directly in the text; the library carries the complete bounded catalogue, DOI links, access status and rights notes.

Study-by-study evidence library

What “all the papers” means in this library

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End-of-life dreams and visions: a longitudinal study of hospice patients' experiences.

Kerr CW, Donnelly JP, Wright ST, Kuszczak SM, Banas A, Grant PC, Luczkiewicz DL.

Study/design/sample: Longitudinal mixed-methods inpatient hospice study; 66 consented, 59 in final analysis.

Results: The official programme reports 88.1% with at least one dream or vision. Reports involving deceased loved ones were especially comforting and became more prevalent near death; most experiences felt real.

Limits: Selected, communicative hospice patients; subjective reports and repeated interviews, not a population-wide rate. Comfort and proximity associations do not establish supernatural causation or predictive accuracy.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

Evidence inspected: Bibliographic record and published abstract

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End-of-Life Dreams and Visions: A Qualitative Perspective From Hospice Patients.

Nosek CL, Kerr CW, Woodworth J, Wright ST, Grant PC, Kuszczak SM, Banas A, Luczkiewicz DL, Depner RM.

Study/design/sample: Inductive qualitative analysis of experiences reported by 63 hospice patients; online 2014, journal issue 2015.

Results: The analysis organized reports around comforting presence, preparation to leave, deceased people, waiting loved ones, distress and unfinished matters.

Limits: Thematic categorization is not a prevalence estimate or validation of what caused the experience. Related programme papers may share a research stream; do not sum their sample sizes as independent replication.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

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Family Caregiver Perspectives on End-of-Life Dreams and Visions during Bereavement: A Mixed Methods Approach.

Grant PC, Depner RM, Levy K, LaFever SM, Tenzek KE, Wright ST, Kerr CW.

Study/design/sample: Cross-sectional mixed-methods study of 228 bereaved family caregivers; online 2019, journal issue 2020.

Results: Families described comfort, reflection and attempts to understand the experience. Crucially, validated Core Bereavement Items scores did not significantly differ between caregivers whose loved ones had ELDVs and other caregivers.

Limits: Self-report, retrospective recall and one hospice programme; associations with comfort are not proof of reduced grief severity or a treatment effect.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

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Attitudes and Perceptions of End-of-Life Dreams and Visions and Their Implication to the Bereaved Family Caregiver Experience.

Grant PC, Levy K, Lattimer TA, Depner RM, Kerr CW.

Study/design/sample: Cross-sectional survey of 500 bereaved caregivers and five self-selected focus groups; online 2020, journal issue 2021.

Results: More positive attitudes toward dreams were associated with greater reported comfort. Negative interpretations related to some less favourable reported bereavement experiences.

Limits: Ad hoc measures, self-selection, prior beliefs and retrospective design. Does not prove that education or dreams cause better bereavement; do not combine its participants with another survey into a verified 750-person cohort.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

Evidence inspected: Bibliographic record and published abstract

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End-of-Life Dreams and Visions and Self-Transcendence: A Comparison Study.

Levy K, Schuster G, Conboy S, Maciejewski H, Grant PC, Kerr CW.

Study/design/sample: Cross-sectional comparison of 72 hospice patients: 35 with ELDVs and 37 without.

Results: No statistically significant difference in measured self-transcendence between groups ($p = 0.310$), and no significant item-level differences.

Limits: A null result is not proof the groups are equivalent. This study did not demonstrate greater self-transcendence in the ELDV group; it should not be recast as a positive result.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

Evidence inspected: Bibliographic record and published abstract

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End-of-life experiences in patients: a scoping review of types, characteristics, and implications for the mind-brain relationship.

Silva TO, Levy K, Kerr CW.

Study/design/sample: Scoping review: 21 papers representing 20 studies, selected from 1,391 citations.

Results: Descriptive reports frequently concerned coherent dreams/visions, deceased loved ones, meaning and comfort; the review also discusses terminal lucidity and possible mind-brain implications.

Limits: Heterogeneous, largely descriptive literature. The authors' proposed mind-brain dissociation is an interpretation, not demonstrated brain-independent consciousness. This 2025 review is distinct from the similarly titled 2023-online/2024 BMJ review.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

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End-of-Life Dreams and Visions: Initial Guidelines and Recommendations to Support Dreams and Visions at the End of Life.

Grant PC, Levy K, Rossi JL, Lattimer TA.

Study/design/sample: Qualitative interviews with 13 multidisciplinary hospice professionals with relevant expertise.

Results: Themes supported rapport, listening, normalization, patient-led meaning and education; the authors proposed initial engagement recommendations.

Limits: Expert-informed initial guidance, not a randomized clinical guideline-validation trial or an objective diagnostic test for ELDVs.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

Evidence inspected: Bibliographic record and published abstract

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Dreams and Visions at the End of Life

Christopher Kerr; Carine Mardorossian

Study/design/sample: Book chapter by Christopher Kerr and Carine Mardorossian in *Spiritual Care in Palliative Care* (2024).

Results: Publisher preview describes a patient-centred account of dreams and visions and their caregiving relevance; no new numerical results are independently verified here.

Limits: Chapter, not a separate clinical trial. Only publisher abstract/metadata were accessible; full chapter is subscription content.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

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Expanding the Understanding of Content of End-of-Life Dreams and Visions: A Consensual Qualitative Research Analysis.

Rachel M. Depner; Pei C. Grant; David J. Byrwa; Sarah M. LaFever; Christopher W. Kerr; Kelly E. Tenzek; Susan LaValley; Debra L. Luczkiewicz; Scott T. Wright; Kathryn Levy

Study/design/sample: Qualitative home-hospice study: 83 patients participated in 842 weekly visits; 548 reports came from 55 patients and were analyzed.

Results: Reports covered relationships, emotion/reflection, activities and settings, including ordinary waking-life concerns as well as meaningful encounters.

Limits: 548 is the number of reported experiences, not people. Selected interview-capable home-hospice population and interpretive thematic analysis; cannot show causal effects or external reality of an experience.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

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End-of-Life Dreams and Visions and Posttraumatic Growth: A Comparison Study.

Levy K, Grant PC, Depner RM, Byrwa DJ, Luczkiewicz DL, Kerr CW.

Study/design/sample: Cross-sectional comparison of 70 hospice inpatients: 35 with ELDVs and 35 without; modified Posttraumatic Growth Inventory.

Results: The ELDV group scored higher on personal strength ($p = 0.012$), spiritual change ($p = 0.002$) and overall growth ($p = 0.019$). Other subscale scores were higher but not all reported as statistically significant.

Limits: Nonrandomized comparison using a modified scale. Direction of causality, confounding and selection remain unresolved; this is not proof that visions produce growth.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

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End-of-Life Dreams and Visions in Pediatric Patients: A Case Study.

Levy K, Grant PC, Kerr CW.

Study/design/sample: Case report of one 15-year-old with terminal glioblastoma and two described ELDV experiences.

Results: Patient and family described comfort and meaning; the account suggests these experiences can matter in pediatric palliative care.

Limits: One adolescent, not evidence of pediatric prevalence, universal peaceful dying or a treatment effect. No metaphysical claim is independently verified.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

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The significance of end-of-life dreams and visions.

Grant P, Wright S, Depner R, Luczkiewicz D.

Study/design/sample: Nursing-practice report of the 66-consent longitudinal hospice research conducted in 2011–2012.

Results: Reports frequent meaningful experiences and increasing comforting deceased-person content near death, translating the foundational work for nursing practice.

Limits: Not a new independent cohort to add to the 2014 longitudinal paper. Care guidance and patient reports do not establish a mechanism or universal rate.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

Evidence inspected: Bibliographic record and published abstract

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Role of Post-Traumatic Growth in Bereavement Outcomes: An Inquiry of Family Caregivers in Hospice.

Grant PC, Levy K, Rossi JL, Kerr CW.

Study/design/sample: Cross-sectional mail survey of 395 bereaved hospice family caregivers; online 2023, journal issue 2024.

Results: More intense bereavement experiences were associated with more reported posttraumatic growth; correlations were modest ($r = 0.134\text{--}0.290$) and one pairing was not significant.

Limits: Growth can coexist with grief. This is not a randomized ELDV intervention and does not show that dreams remove suffering or cause healthier bereavement.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

Evidence inspected: Bibliographic record and published abstract

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Medications Not Dosed Within Recommended Range for Renal Function in Patients With Chronic Kidney Disease Identified upon Hospice Admission; a Retrospective Chart Review.

Latuga NM, Levy K.

Study/design/sample: Retrospective review of 283 hospice-admission charts; online 2025, later journal issue 2026.

Results: 27% had at least one renally cleared medicine dosed above the study's recommended renal-function range; medication number and renal-function markers were associated with risk.

Limits: Included because it appears on Kerr's research page, but it is a medication-safety adjunct, not a dream/vision study. Retrospective prescribing assessment does not establish medication harm in each patient or justify self-adjusting doses.

Relation to the interview: Included to account for the research-page listing; not evidence for the interview's dream or consciousness claims.

Evidence inspected: Full institutional PDF inspected

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Hospice Patient Care Goals and Medical Students' Perceptions: Evidence of a Generation Gap?

Levy K, Grant PC, Kerr CW, Byrwa DJ, Depner RM.

Study/design/sample: Survey comparing 80 hospice patients with 176 medical students (97 first-year, 79 third-year); 11 care goals; online 2020, journal issue 2021.

Results: Students ranked seven of the 11 goals differently from patients. Third-year students were less successful at perceiving patients' goals; empathy did not significantly differ by student year.

Limits: One patient/student setting. Rankings are relative to selected options and cannot establish that nobody regrets anything. The abstract supports group differences; every rank in the interview chart was not independently audited.

Relation to the interview: High-confidence match to the 19:11 patient-priorities comparison; authors and full citation not spoken.

Evidence inspected: Bibliographic record and published abstract

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Meaning-centered dream work with hospice patients: A pilot study.

Wright ST, Grant PC, Depner RM, Donnelly JP, Kerr CW.

Study/design/sample: Exploratory pilot of 12 meaning-centred dream-work sessions with seven hospice patients; online 2014, issue 2015.

Results: Participants described the sessions as useful and meaningful, linked dreams to current concerns and sometimes made practical plans. No adverse effects were reported in this small pilot.

Limits: Very small, uncontrolled feasibility study; not proof of clinical efficacy or of safety in a broader population.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

Evidence inspected: Bibliographic record and published abstract

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The impact of dreams of the deceased on bereavement: a survey of hospice caregivers.

Wright ST, Kerr CW, Doroszczuk NM, Kuszczak SM, Hang PC, Luczkiewicz DL.

Study/design/sample: Survey of 278 bereaved people about their own dreams of deceased loved ones; online 2013, issue 2014.

Results: 58% reported dreams of the deceased. Respondents described comforting and mixed emotional effects, including acceptance and sadness.

Limits: Dreams experienced by surviving caregivers are not dying patients' ELDVs. Retrospective self-reports cannot establish external contact or a causal grief-treatment benefit.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

Evidence inspected: Bibliographic record and published abstract

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Understanding Clinicians' Perspectives on End-of-Life Dreams and Visions: An International Survey.

Hamza Habib M, Fontanesi L, Motiwala ZY, Çöltekin A, Misra S, MacLulich A, Vinay R, Hertler C, Blum D, Singler K, Simões C, Frisardi V, Boccardi V, Bellelli G, Koca M, Kerr CW, Jones CA, Peng-Keller S, Schlögl M.

Study/design/sample: International online survey: 303 submissions, 271 complete, 247 retained after 24 response-time exclusions.

Results: 18.6% had never encountered patient reports of ELDVs; 9.3% had relevant training. Respondents reported positive effects more often than negative effects and prioritized better protocols and diagnostic criteria.

Limits: Voluntary professional-network sample, with most respondents in North America. Practitioner exposure is not patient prevalence, and perceived benefit is not an independently measured treatment outcome.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

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End-of-life experiences in the dying process: scoping and mixed-methods systematic review.

Silva TO, Ribeiro HG, Moreira-Almeida A.

Study/design/sample: Scoping review identified 115 reports; mixed-methods synthesis included 36 papers describing 35 studies. Online 2023; journal issue 2024.

Results: Reports commonly involved deceased people and preparation for travel; experiences were generally interpreted positively, with differences by patient, family or professional respondent.

Limits: Broad end-of-life-experience category, heterogeneous methods and predominantly observational reports. Not a controlled test of an afterlife, and distinct from the 2025 Silva/Levy/Kerr review.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

Evidence inspected: Bibliographic record and published abstract

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Wisdom at the end of life: Hospice patients' reflections on the meaning of life and death

Scott T. Wright; Jennifer M. Breier; Rachel M. Depner; Pei C. Grant; Jennifer Lodi-Smith

Study/design/sample: Qualitative study of 15 terminally ill hospice patients; published online 2017, journal issue 2018.

Results: Patients discussed humility, learning, self-understanding, relationships, spirituality, vocational fulfillment and changing priorities. Accounts included regrets as well as growth.

Limits: Small qualitative sample; does not establish that all dying people share the same priorities or have no regrets. Not a prevalence study of ELDVs.

Relation to the interview: Official programme publication relevant to the interview; not a verified identification of an individual paper on the host's desk.

Evidence inspected: Publisher abstract surfaced by exact-title search; bibliographic metadata

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Nationwide Japanese Survey About Deathbed Visions: My Deceased Mother Took Me to Heaven

Morita et al.

Study/design/sample: invited: 3964; responses: 2827; analyzed: 2221; deathbed vision reports: 463

Results: Deathbed visions reported in 21% of analyzed family responses (95% CI 19–23%). Good-death scores did not significantly differ between vision-report and no-vision groups. Family depression was 20% versus 16%, adjusted $P=.068$: not conventionally statistically significant, and not evidence visions caused depression. 81% considered neutral clinician discussion necessary or very necessary rather than automatic medical-pathology labeling.

Limits: A large independent counterweight to universal 90% or universal benefit claims, but not an apples-to-apples replication: proxy retrospective reports and narrower deathbed-vision framing differ from repeated direct patient interviews. Reporting correlated with demographic and belief-related factors; cultural context and selection/recall can influence estimates. Association is not causation; neither improved nor worsened bereavement is established by this survey.

Relation to the interview: Independent contextual comparison, not a paper specifically identified by title in the interview.

Evidence inspected: PubMed record and extracted accepted-manuscript text

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End-of-life dreams and visions in a patient with delirium: A Brazilian case report and narrative review

Taís Oliveira Silva; Bruno Angeli-Faez; Lorena Cândida Ferreira Paixão; Everton de Oliveira Maraldi; Alexander Moreira-Almeida

Study/design/sample: One 61-year-old woman with metastatic lung cancer, followed by a home palliative team for 46 days; CAM assessed on 13 visits.

Results: ELDV-like vivid, biographically meaningful experiences and delirium co-occurred; some experiences were distressing. Authors describe lucid windows and coherent recall, but warn that emotional valence alone does not distinguish ELDVs from delirium. CAM identifies delirium, not the meaning or ontological status of the experience.

Limits: Illustrates why the simple binary 'delirium is frightening; visions are peaceful' is unsafe. Single case cannot validate diagnostic criteria or establish how often coexistence occurs. Authors' phenomenological classification is not a definitive biomarker.

Relation to the interview: Independent contextual comparison, not a paper specifically identified by title in the interview.

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End-of-life dreams and visions: A systematic integrative review

Alison Hession, Tim Lockett, Sungwon Chang, David Currow, Michael Barbato

Study/design/sample: Evidence synthesis; see findings for study counts.

Results: 22 papers representing 18 studies. Pooled patient reports: 77% (95% CI 69–84%; n=119). Pooled bereaved-family reports: 32% (95% CI 21–44%; n=2444). 80% of healthcare professionals (n=171) reported witnessing or hearing about an ELDV in the previous five years. This is not the proportion of their patients who had an ELDV. Comfort is recurrent, but settings, definitions, respondent types and reporting periods vary. Authors identify sparse acute-care research and methodological limitations.

Limits: Patient pooled denominator is only 119, not thousands. Do not blend patient, caregiver and professional percentages into one prevalence estimate. Review explicitly excluded near-death experiences in populations not approaching end of life; hospice ELDVs are not equivalent to post-resuscitation NDEs. Institutional author-copy availability does not itself establish a rehosting license.

Relation to the interview: Independent contextual comparison, not a paper specifically identified by title in the interview.

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Deathbed Phenomena, Other End-of-Life Experiences and Their Effects in Palliative Care Teams: A Systematic Review

Manuela Bertão, Úrsula Dalcolmo, Francisca Rego

Study/design/sample: Evidence synthesis; see findings for study counts.

Results: 12 eligible articles from 7095 records; reported prevalence 28–87%, with dreams and visions most common.

Limits: A range across heterogeneous end-of-life experiences is not a pooled ELDV prevalence. Abstract's percentages for themes such as comfort/not comfort and grief are frequencies of themes across papers, not patient response rates. Authors' therapeutic language does not create randomized evidence of improved grief or a peaceful death.

Relation to the interview: Independent contextual comparison, not a paper specifically identified by title in the interview.

Evidence inspected: Published abstract and bibliographic record

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Heritability of intrinsic human life span is about 50% when confounding factors are addressed

Ben Shenhar et al.; senior author Uri Alon

Study/design/sample: Mathematical modelling and reanalysis of three Scandinavian twin datasets, including Danish/Swedish historical cohorts and SATSA twins raised together/apart; additional US centenarian-sibling analysis. SATSA restriction: born 1900–1935 and both twins survived to age 61. Main text reports groups $n=150$ MZ raised apart, $n=371$ DZ raised apart, 196 MZ and 325 DZ raised together; no pooled real-person sample total asserted here. Figure's $n=5000$ MZ twin pairs are simulated, not recruited participants.

Results: After modelling extrinsic mortality and cutoff-age effects, estimated heritability of intrinsic lifespan was 0.55 ± 0.01 SE. Defined under zero extrinsic mortality and a cutoff age of 15, conditional on reaching maturity; not an estimate that 55% of an individual's life is genetically predetermined.

Limits: Model-based extrapolation depends on separation of intrinsic/extrinsic mortality, twin assumptions and survival/cutoff selection; older datasets lack sufficiently detailed cause-of-death data. Population/environment-specific heritability is not individual destiny, and does not say lifestyle or prevention is ineffective. Not a trial of longevity interventions and not evidence for indefinite life extension. Final PDF includes correction dated February 20, 2026: funding grant-agreement number corrected, not results. No correction flag appeared in PubMed XML, illustrating why final full text matters.

Relation to the interview: High-confidence identification from the explicitly named journal Science, recent timing and 55% result at 43:00; authors/title not spoken in the excerpt.

Evidence inspected: Final published university-hosted PDF inspected, including correction notice

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Global Healthspan-Lifespan Gaps Among 183 World Health Organization Member States

Armin Garmany and Andre Terzic

Study/design/sample: Retrospective cross-sectional national-level analysis of 183 WHO member states using WHO Global Health Observatory estimates for 2000–2019; no individually recruited patient cohort.

Results: Global gap increased from 8.5 years in 2000 to 9.6 in 2019. US gap increased from 10.9 to 12.4 years, largest among the analyzed countries. Women globally had a mean 2.4-year larger gap than men.

Limits: Gap is life expectancy minus health-adjusted life expectancy, a population measure using disability weights—not necessarily an individual's final consecutive years of illness. Relies on modelled health estimates and disability weighting; country-level associations cannot establish individual causation. Data end in 2019, not 2024 or 2026; publication date is not observation date.

Relation to the interview: Contextual likely companion to 42:00 discussion, NOT directly identified: interview gives no title/journal and says roughly 11 US years. This paper's 2019 US value is 12.4 years; 10.9 years refers to 2000.

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Psilocybin produces substantial and sustained decreases in depression and anxiety in patients with life-threatening cancer: A randomized double-blind trial

Roland R Griffiths et al.

Study/design/sample: Randomized double-blind crossover trial in 51 patients with life-threatening cancer and depression/anxiety symptoms. High-dose versus very-low-dose psilocybin with structured professional support, crossover at five weeks, six-month follow-up. NCT00465595.

Results: High dose produced large reductions in clinician/self-rated depression and anxiety and improvements in quality of life and death anxiety. Abstract reports about 80% continuing to show clinically significant depression/anxiety reductions at six months.

Limits: Small, highly selected, predominantly White and highly educated sample; blinding/expectancy remain difficult. After crossover there was no untreated parallel comparator, so six-month persistence is not six months of randomized comparative efficacy. Not all participants were in their final days; trial does not establish that all treated people die peacefully, that fear vanishes universally, or that the brain is structurally altered. No serious adverse events attributed to psilocybin in this small trial, but transient blood pressure rises, nausea and psychological distress occurred; this is not evidence that unsupervised use is safe.

Relation to the interview: Contextual companion, not named in the interview's general discussion of psychedelics/dying patients at 50:53–51:34.

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Rapid and sustained symptom reduction following psilocybin treatment for anxiety and depression in patients with life-threatening cancer: a randomized controlled trial

Stephen Ross et al.

Study/design/sample: 29 patients with cancer-related anxiety/depression randomized in double-blind crossover comparison of psilocybin and niacin, both with psychotherapy; primary between-group assessment before seven-week crossover. NCT00957359.

Results: Before crossover, psilocybin improved anxiety, depression, demoralization, hopelessness, spiritual wellbeing and quality of life. At 6.5-month follow-up approximately 60–80% continued with clinically significant depression or anxiety reductions, alongside improved attitudes toward death.

Limits: Small, nonrepresentative sample (62% women, 90% White); active placebo provided limited blinding. Crossover limits long-term causal interpretation; psychotherapy and structured support are part of the tested intervention. Clinical distress outcomes and mystical-experience ratings do not verify an afterlife or brain-independent consciousness, and do not demonstrate anatomical brain change.

Relation to the interview: Contextual companion, not explicitly named in the 50:53 discussion.

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The Paradox of Dying: Spiritually and Emotionally Alive at the End-of-Life

Hannah Maciejewski; Christopher W. Kerr

Study/design/sample: Chapter in On the Banks of River Styx, pp. 119–132, as listed in the official toolkit.

Results: A narrative contribution on dying and emotional/spiritual experience. No new quantitative findings have been independently verified from the full chapter.

Limits: The chapter is not a separately verified clinical trial. Publisher excerpt/bibliographic listing does not establish access to the whole chapter.

Relation to the interview: Supporting programme resource or contextual source; not counted as a journal research paper.

Evidence inspected: Toolkit bibliography and publisher book/excerpt material

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Death Is But a Dream: Finding Hope and Meaning at Life's End

Christopher Kerr, with Carine Mardorossian

Study/design/sample: Trade book presenting patient accounts and the research programme.

Results: Explains the clinical and personal meaning of end-of-life dreams and visions; not a new independently enrolled study.

Limits: Narratives and selected accounts should not be counted as a new clinical trial. Full copyrighted book not reproduced or represented as fully audited.

Relation to the interview: Supporting programme resource or contextual source; not counted as a journal research paper.

Evidence inspected: Publisher catalogue/description and official research listing

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End-of-Life Dreams & Visions Toolkit

Hospice & Palliative Care Buffalo research team; component tools credited in the document

Study/design/sample: Institutional resource combining research summaries, clinical suggestions, patient/family worksheets and bibliography; some component tools carry earlier version dates.

Results: Provides ways to discuss experiences without imposing interpretations. Explicitly distinguishes the programme from proving an afterlife and includes guidance for distressing experiences.

Limits: An educational toolkit is not another clinical trial or validated diagnostic algorithm. Full original is available from the institution, but no unrestricted redistribution licence was established.

Relation to the interview: Supporting programme resource or contextual source; not counted as a journal research paper.

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Many Americans report interacting with dead relatives in dreams or other ways

Pew Research Center

Study/design/sample: Survey of 5,079 US adults, March 27–April 2, 2023.

Results: 53% reported ever being visited by a deceased family member in dreams or another form. 34% reported dreaming of a deceased family member in the previous 12 months.

Limits: Question wording and time windows differ. Reports are not verification of external contact; the survey did not resolve natural versus supernatural interpretations. Not a hospice sample.

Relation to the interview: Supporting programme resource or contextual source; not counted as a journal research paper.

Evidence inspected: Original Pew article and methodological description

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Last Days of Life (PDQ) — Health Professional Version

National Cancer Institute PDQ Supportive and Palliative Care Editorial Board

Study/design/sample: Evidence-based institutional clinical summary, principally advanced cancer.

Results: Discusses symptom relief, frequent hypoactive delirium, and potentially comforting deceased-person experiences. Reports pain in 30–75% of patients in cited last-days literature, while emphasizing that most can obtain relief.

Limits: Disease/setting-specific evidence and clinical guidance, not a new ELDV study or a universal prediction. Supports assessment rather than assuming peaceful accounts rule out delirium.

Relation to the interview: Supporting programme resource or contextual source; not counted as a journal research paper.

Evidence inspected: Official NCI clinical text inspected

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