# Breathing in Mortality: Demedicalization of Death in Documentary Films

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***Abstract:*** *The 20th century saw a strengthening of medicalization processes, which included a medicalization of death where dying and death came to be handled primarily as medical challenges. For their part, cinematic technologies participated in this by utilizing film technology to standardize medical processes, by using films for educational purposes, and by representing medical technology and knowledge in an authoritative sociocultural manner in film narrations. As a side effect, cinematic narratives have often portrayed death as a medical failure that people can and need to be saved from. Toward the end of the 20th century, criticism toward medicalization has increased among healthcare personnel and hospice and palliative care movements, for example. At the same time, as documentary films have continued to try to capture and understand the dying processes, in at least those films dealing with so-called natural death (due to aging or terminal illness), their tone has started to emphasize demedicalization aspects. I argue that this change in tone is recognizable in how the cinematic technology represents and utilizes breathing in the films' narratives. Breathing—and particularly difficulty breathing—audibly and visibly embodies the fragility of the human body before death. At the same time, it conveys a sense of agency: Are you able to breath on your own? Is medical technology needed to do breathing for you? And how is the use of technology for dying individuals justified or not? I analyze the documentary films* Dying at Grace *(2003),* Frontline: Facing Death *(2010),* Love in Our Own Time *(2011),* Extremis *(2016),* ISLAND *(2018), and* Covidland *(2021), and through them I argue that 21st-century documentary films are joining in the efforts to demedicalize death and, as such, they are shifting the long relationship between cinematic and medical technologies.*

## Introduction

Cinematic technology has explored whether a camera can reveal and document what death is, as an event (medically speaking) and as an experience. Yet, the recording of death has proven to be problematic. The medium has limits on how to reach beyond cinematic representation, and death refuses to be fully communicated through narrative, aesthetics, and the affective options that cinema offers (Malkowski, 2017; Sobchack, 1984). Despite the limitations of the medium,

filmmakers have continued their attempts to capture the moment of death and, in this process, breathing has become an important narrative tool for both cinematic and medical purposes.

An absence of breathing and a heartbeat (or respiratory and circulatory arrest) served as the medical definition of death well into the 20th century (Saeed, 2018). Since the 1950s, the invention of mechanical respirators and other life-supporting technologies has led to the current practices of measuring brain function to define death (Maguire, 2019; Saeed, 2018). Yet, changes in breathing, such as difficulty breathing and lack of breath, continue to serve as diagnostic tools in several illnesses and the moment of impending death, and these can be perceived as image and sound by film audiences. Closer to death, difficulty breathing can shift to agonal breathing, where the automated process of breathing becomes difficult and a conscious effort, a medical sign that the person is getting weaker (Fletcher, 2018). Finally, the final stage of dying can often be detected by a death rattle, which can develop during the last hours of life when the patient is too weak to swallow and the airway secretions produce gasps in breathing (Campbell, 2019; Wee et al., 2006). These stages of breathing communicate the medical conditions of the patients, and in documentaries they can be used as ways to overcome the sensory limitations of representing dying as a process.

In medical research, breathing has been discussed in relation to diagnostics, several long-term and acute illnesses, and life support and death (Bausewein et al., 2007; Dorman et al., 2007; Hutchinson et al., 2017). While part of this research focuses on symptoms and treatments, the research has also placed importance on the experiences of breathlessness. Research has shown that people experiencing difficulty breathing can feel failure or an otherness of their bodies, which affects their sensations, thoughts, feelings, and behavior (Malpass et al., 2019). Breathlessness not only limits their lives physically, but also socially, psychologically and existentially, and it can create a sense of loss or hopelessness and an awareness of mortality and the temporality of life (Górska, 2016; Hutchinson et al., 2018; Macnaughton & Carel, 2016; Malpass et al., 2019; Malpass & Penny, 2019). Thus, while breathing serves as a medical diagnostic and observational tool, it also puts the focus on the patients, their experience of loss, and an oft-related fear of death—an affective experience that cinematic media and storytelling are capable of conveying for viewers. After all, cinematic experience can transform the viewers' understanding of issues they have not experienced themselves, for example, to give insight into death and dying.

Yet, in film studies, breathing has received limited attention. Quinlivan (2012) argues that breathing can be a powerful instrument for narration, visual and audio effects, meaning-making, and embodied experiences. When made the focus of a film, breathing has intense emotional and visceral impact, not least because of viewers' tendency to respond to on-screen representations mimetically or affectively. Thus, in moments where breathing is the focus of narration, viewers not only become sensitive to the on-screen breathing bodies, but their own bodies can start to mimic those of the breathing characters, creating an embodied experience and bodily awareness (Fahd, 2019; R. Gibson, 2013; Quinlivan, 2012). This potential for bodily self-awareness and an embodied connection with dying people invites viewers into affective experiences of the dying process in a way that can overcome the limitations of cinematic (and medical) technology.

In this article, I discuss how health-related documentaries with a focus on end of life utilize breathing as narrative and an embodied tool to explore the potential and limits of communicating death and dying through cinema. The discussion is related to my research project on end-of-life documentary films. After watching over fifty documentaries on the topic, I started to notice the role of breathing as a signifier of dying. For this article, I chose examples that give prominence to this narrative solution and highlight the complexity of meanings that are embedded to this

signifier. My analysis will show that breathing as a signifier of death has also cultural and political goals. When the documentaries represent a contrast between independent breathing and breathing with respiratory devices, they discuss the practices of medicalization of death, where death and dying have become defined and handled primarily as medical challenges (Conrad, 2007; Sadler et al., 2009; Tabernero, 2018).

Both medical and cinematic technologies have appeared as signs of modernity from the beginning of the 20th century. Medical professionals have used film technology to document and standardize medical procedures and to serve for educational or verification purposes within the field (Dijck, 2005; Ostherr, 2013). In addition, the cinematic media has eagerly participated in building images of scientific technology as something that should have authority and sociopolitical importance (Tabernero, 2018). Both documentary and fictional film and television representations of the medical field have imagined and conceptualized medical knowledge and technology as a kind of salvation, and consequently, they have portrayed death from natural causes as a (medical) failure that people need to be rescued from (Dijck, 2005, pp. 14, 33–34; Hetzler & Dugdale, 2018, p. 767; Ostherr, 2013, pp. 168–169). However, when it comes to mediating death as a transformative moment in human life, cinematic expressions have faced difficulties in capturing the totality of the dying experience. These difficulties are similar to those of the medical field, where definitions of death remain controversial, for example due to coma and brain death. Similarly, no matter how much the images of the dying process are slowed down in cinematic representations, realizing the exact moment that could be studied for modern (medical) gaze can remain out of reach.

In recent documentaries of natural death occurring due to age or illness, the cinematic medium continues in its attempts to mediate death as an experience, but instead of medicalization purposes, these tend to aim to demedicalize death, to define it as a normal part of life in a way that highlights the person, not the medical issues or death as a failure. In particular, I pay attention to how breathing narratives help to justify the demedicalization of death. With a combination of cinematic and medical perspectives, I illustrate the twofold connections that on-screen dying bodies have with technology. Both medical technology, such as ventilators, and cinematic technology, such as cameras, create the embodied potential for viewers to gain perspectives on the medicalization of death and dying in contemporary societies. While cinematic technology has added to the medicalization processes in the 20th century, I argue that documentary films of the 21st century challenge the idealization of modern medicalization processes.

## Narrative Aspects of Intensive Care and Hospice Care Documentaries

I approach the role of breathing in demedicalization narratives through theoretical and methodological practices of narratology, which studies structures and functions of narratives. Specifically, I focus on two constitutive building blocks for both stories and human experiences: space and time. The narrative events take place in various environments and locations, whether real or imagined, and they enable contextual and metaphorical depth for stories (Ryan, 2012). Similarly, narration takes place in a temporal setting that gives the stories a sense of direction and tempo (Parker, 2018). Together, space and time situate both the characters and the viewers in the stories.

Two different care locations define the end-of-life documentaries that I analyze in this article. First, I study medical documentaries about intensive care units (ICUs), which provide critical care, life support, and constant surveillance for patients whose lives are at immediate risk.

I study the hour-long television documentary *Frontline: Facing Death* (Navasky & O'Connor, 2010), the Netflix documentary *Extremis* (Krauss, 2016), and a topical short documentary *Covidland* (Teitler, 2021). Second, I analyze documentaries about hospice and palliative care where the focus is on comfort care and the experiences of the dying patients. The following three documentaries also include the last breaths of the dying people: *Dying at Grace* (King, 2003), *Love in Our Own Time* (Murray & Hetherton, 2011), and *ISLAND* (Eastwood, 2018).

Both ICUs and hospice spaces provide spatial frames with patients in their hospital beds, surrounded by staff and family members. Yet, medical (and cinematic) technologies play different roles in these spaces. In the ICU, the medical technology, particularly ventilators, occupies a key spatial role, and the film camera maintains some distance from the patient. In comparison, the home-like environment of hospices marginalizes medical technology and brings film cameras close to the patient.

Differences in settings bring forward differences in the medical and sociocultural contexts of care. The medicalization of death has been connected to highly technologized intensive care, even when many ICU professionals (and others) have raised concerns about the dehumanizing aspects of the overmedicalization of dying (Hetzler & Dugdale, 2018, p. 767). Overmedicalization includes an aggressive aim to prolong life through medical interventions, such as ventilators, which arguably turns patients into isolated medical objects, whose individual autonomy and social and emotional wellbeing are marginalized (Field, 1994; L. K. Hall, 2017; Hetzler & Dugdale, 2018; Zimmermann & Rodin, 2004). In comparison, the rise of hospice movements appears as an alternative for medicalized death and as a transition toward demedicalized dying (L. K. Hall, 2017, p. 235). Hospice care and palliative care focus on holistic end-of-life care, where medical care treats symptoms and aims for comfort care (instead of a cure), and which is complemented with psychological, social and spiritual care to increase the level of quality of life (Loscalzo, 2008; Radbruch et al., 2020). Similarly, in the documentaries, the ICU films give the central role to the medical technology, whereas the hospice films tend to avoid technological aspects and focus on the patients' experiences.

In addition to setting, the framing of images adds spatial aspects to film narration. The framing defines which elements, such as breathing, are given focus and visibility on screen. Quinlivan (2012) has observed that breathing shows itself through cinematic place—it is something that is made visible (and heard) particularly through breathing bodies on screen. Because documentaries about natural death put special focus on the breathing of the dying main characters, who are either breathing independently or with a ventilator, these films also construct the spatial potential for an embodied connection. Thus, by looking into the images and sounds of breathing, I analyze how viewers are invited to pay attention to breathing, and how this direction of attention can challenge medicalization processes.

Time serves as another important motivation, both in the narratives and in end-of-life care. Medicalization, with its medical interventions and technology, aims to either prevent or slow down dying and to increase one's lifespan. The demedicalized death is often embraced if there is no longer hope for other results. Thus, the ethical dilemmas of end-of-life care lie in the uncertainty of the prognosis: the best course of care decisions—curative versus palliative care—can often be realized only in hindsight. Thus, the ambivalence of temporality of life muddies the waters for medical staff, patients, and their families.

In contrast, documentaries have a built-in hindsight to evaluate medicalization of death due to the editing and post-production practices where filmed events are turned into a narrative. Heidegger's metaphysics of "being-toward-death," according to which death gives perspective to

all experiences and guides our (temporal) way of being in the world (Heidegger, 1978), serves as a starting point for Ricoeur, who argues that the temporal structure of human experience is comparable to the temporality of narrative, where events are both projected toward a certain future and informed by the past. This structure of "having-been, coming-forth, and making-present" gives the narrative a circular form where the end is anticipated in the beginning, and the beginning is included in the end (Ricoeur, 1980, p. 181). In end-of-life documentaries, the viewer is aware of impending death from the beginning, and thus the narration is burdened with anticipation of death, a strong attitude of "being-toward-death." Breathing, changes in breathing, and lack of breathing mark this anticipation, the passing time, and progressing dying process.

Along with the passing of universal time, breathing marks the embodied time in these documentaries. Instead of universal (or clock) time, embodied time refers to the experience of time, and its importance is recognized by both the medical and cinematic fields. Studies of hospice and palliative care have emphasized the patients' experience of time becoming embodied: terminally ill people mark outer universal time as less important than their inner time, and their end of life is defined by changes in their bodily functions and lived experiences (Lindqvist et al., 2008), where "it is not the clock that stops ticking, but the heart that stops beating, when lifetime is ended" (Ellingsen et al., 2013, p. 170).

Similarly, in phenomenological philosophy, time is often seen as a "dimension of our being" instead of a universal object (Merleau-Ponty, 2002, p. 438), and in film theory, Deleuze has argued that while images move within a certain time, they can relate to time also indirectly or virtually in ways that underline experienced, not universal time (Deleuze, 1985, pp. 24–44). When on-screen breathing characters experience time through their bodies, they mediate an embodied potential for the viewer to connect with their experiences.

In addition, "being-toward-death," or anticipation of death, creates non-linearity in the narration, making the experience of time fluid. The fluidity of time that is connected to lived body experiences gives depth to the cinematic expression. According to Sobchack (2004, p. 121), temporal simultaneity also expands the space of presented images, and as such, the temporal aspect of the images includes and affects the spatial and material bodies in them. In the following analysis, I utilize this idea that the spatial and temporal aspects related to breathing serve as narrative tools to visualize and embody dying processes in a way that can reveal these documentaries' relationship to ideas of (de)medicalization. I start the analysis with the ICU documentaries before discussing the hospice and palliative care documentaries.

## Breathing and Agency in Intensive Care Documentaries

The contemporary medical documentaries that narrate the daily lives of intensive care units are influenced by the traditions of cinma vrit and observational documentaries, where events take place in front of viewers with no voice-over commentary, added music or sound effects, often being filmed with a hand-held camera as if to emphasize a "real" feeling (J. Hall, 1991; MacDougall, 2018, pp. 1–2; Nichols, 2017, pp. 132–135). This style was eagerly utilized in early medical documentaries, where viewers were invited to witness hospital life behind the scenes; ambient sounds, such as beeping and machine sounds, as well as images of medical technologies, such as a dialysis machine, ventilators, and heart monitors, provided an impression of unmediated reality, and the institutional feeling of rushing doctors gave a sense of authenticity (Ostherr, 2013, p. 157). All three ICU documentaries—*Facing Death*, *Extremis*, and *Covidland*—utilize this tradition at least partially by highlighting the sense of being present,

offering observation, and witnessing the practices, potential and limitations of intensive care. By placing the care practices under scrutiny, the contemporary films also turn a critical gaze toward the medicalization of death.

In *Extremis*, a short documentary that depicts the ICU of Highland Hospital in the U.S., the challenges related to medicalization of death become visible through two patients, Selena and Donna. In both cases, their families face a conflict about whether they should be maintained on a ventilator or allowed to die by being removed from life support. In the end, Donna's family decides to remove the tubes, and Donna says goodbye to her family before passing away a day later. Selena is surgically attached to the ventilator until her death about six months later.

Because Selena is unable to communicate or respond to stimuli, the family needs to make care decisions for her. Consequently, there is very limited on-screen time for the patient, and the narrative focus is on the family, which is struggling with a sense of loss and care choices. For them, the high-tech medical technology equals life, the decision to remove the ventilator equals murder, and death equals failure in medical care. Thus, medicalization provides hope and a prolongation of life (and time); the roots for these kinds of expectations have been sought from media narratives. Medical programming, where trauma patients can be "fixed" and life-sustaining treatments are emphasized at the expense of long-term outcomes of medical interventions or benefits of palliative care, has been argued as giving families misguided expectations of ICU care (Hetzler & Dugdale, 2018; Houben et al., 2016). Although Selena's family's (unrealistic) sense of hope is merely observed, not openly criticized, the choice to leave the patient as part of the background, not the central focus, questions whether the medicalization of death is in the interest of the family, not the patient.

The desire for demedicalization is further highlighted with Donna. The viewer is introduced to her when she is strapped to a hospital bed and breathing with the help of the ventilator. The beeping sound of the EKG machine and the whooshing sound of the ventilator make the medical technology spatially present through audio and visual imagery. This introduction highlights the role of medical technology, and mechanical breathing seems to replace Donna's agency. The sounds diminish when her husband starts talking to her soothingly. The husband even confesses being worried that the ventilator is the only functioning thing. Later on, Donna is able to respond to the doctors and her family, and she signals that she wants to have the breathing tube removed. Her part of the film finishes with her own words, when after the removal of the tube she smiles and tells everybody to calm down. She regains her own breathing, and her own voice, and she and her family choose to accept the impending death. The medical treatments or technology no longer intervene in the goodbyes and communication. At the same time, her death is not portrayed as failure, but as a rite of passage. In subtle ways, the documentary compares these two end-of-life care choices in a way where mechanical breathing prolongs life yet also relieves the patient from agency.

The connection between agency and breathing is highlighted in the Public Broadcasting Service's documentary *Frontline: Facing Death*, which features an emergency care unit at Mount Sinai Hospital in New York City. The film introduces doctors dealing with intensive care and aggressive medical interventions, and patients and their families who are dealing with various terminal diagnoses. Here, too, the focus is on care choices, and the documentary discusses conflicts between the hopes related to medicalization and the fears of overmedicalization, where invasive and aggressive treatments can affect quality of life and sometimes even shorten life. While the filmmakers seemingly present both sides of the argument, the spatial and temporal narration challenges the outcomes of overmedicalization. Spatially, the dependence on medical

technology becomes a focal point. Mechanical ventilation plays a particularly significant role, as it assists or replaces the breathing of the patients. The ventilators also marginalize the patients, who become almost unrecognizable beneath tubes attached to medical devices.

For example, one scene starts with a close-up of the illuminated screen of the medical device that measures oxygen levels and breathing. Slowly the camera pans to the breathing tube and follows its movements in the regulated rhythm of breath. The camera focuses on this movement in an almost hypnotic way. The rhythm of breathing in and out is also a form of engagement—with each intake of breath, people take something of the world into themselves, and when breathing out they release something out of themselves and participate in the shared world (Quinlivan, 2012, pp. 104–105). Thus, when patients are unable to breathe for themselves, technology, at least temporarily, overtakes their subjectivity. In *Facing Death*, where the patients die despite medical interventions, the visual allegory of borrowed breathing asks whether the medical options provide meaningful life. In this scene, the image continues to refocus, from the breathing tube to giving a glimpse of the patient at the end of the tube. Even here, their face remains out of focus, unrecognizable. This image contrasts with the medical technology, the breathing mask, and its timely and precise movements, which are in focus, with the blurred and unstable image of the person.

While the spatial aspect of breathing questions the limits of human agency in connection to medicalized death, temporal aspects raise questions of being-toward-death. Respiratory machines give time for families to make decisions about end-of-life care and to come to terms with loss. The medical staff highlights that this treatment should be temporary, but for many families it is hard to decide when to stop it, as intensive care can give false hope that modern technology could prevent dying. In many ways, medical technology freezes embodied time, yet by extension it also freezes the agency and subjectivity of the patient. In *Facing Death*, none of the patients get better, and at the end of the documentary, only one patient—who is permanently hooked to a breathing machine—continues to live. The question whether the patients can breathe on their own gives narrative structure and tension to the film, and the removal of the breathing technology becomes the closing scene of the documentary. This implies that unless you can breathe yourself, you have neither agency nor meaningful life, and the question raised is how the relatives are going to deal with this loss.

Whereas *Extremis* and *Facing Death* question the suitability of medicalized ICU care for terminally ill patients at the end of their lives, the COVID-19 pandemic discusses impending death in the context of acute illness—the primary function of ICU care—where difficulty breathing is a sudden, and unwelcome, reminder of mortality. *Covidland*, where ICU doctor Megan Panico cares for COVID-19 patients at Hartford Hospital, witnesses how COVID emergency care affects both healthcare personnel and the patients. While emotional strain comes to the fore, medical technology represents hope to save lives amidst the pandemic. As a respiratory disease, COVID-19 affects lungs, and in severe cases coronavirus can cause acute respiratory distress syndrome, a life-threatening lung injury, where oxygen cannot get into the body, and which often requires intensive care with oxygen or a ventilator (World Health Organization, 2020). The care aims to support the patient so that the body has time to heal. In *Covidland*, medical technology is presented as an option to freeze embodied time.

This short documentary also starts with images from an ICU corridor filled with monitors and medical technology. Mechanical beeping sounds and close-ups of blood pressure monitors and IV therapy bags surround the staff as they put on their personal protective equipment. While the contextual images highlight the need for medical technology for life support, the images

of the staff reference the threat of infection. Here, breathing acquires dangerous undertones. Participation in the world through breathing becomes both a blessing and a curse, when every intake of breath can expose one to a virus, and every outbreath can cause danger to others. In this context, breathing carries both positive and negative connotations. The opening ends with the staff members looking into a patient's room through a glass window. Thus, before the viewer is allowed to meet the patients, the need for protection is introduced, highlighting the isolation of patients.

The short film tells the story of a patient, Brian, who according to the closing credits died from COVID. He is introduced through medical technology: the camera pans from the machines by the bedside to Brian, whose face is hidden beneath an oxygen mask. Similarly to other ICU films, the image does not linger on Brian, but cuts to the staff's discussion of his medical status. When the camera finds Brian again, the only movement is his chest, as he struggles to breathe even with the mask. The medical technology hums in the background.

Later on, when Brian is involved with discussion of his care, the medical technology—both visual and auditory spatial cues—also fades into the background, and low-key background music is introduced. It covers the sound of the machines and gives priority to the agencies of both the patient and the caretaker. When Dr. Panico discusses Brian's views on having to be intubated, and potentially dying with a breathing tube, distress and the inability to decide are visible in Brian's facial expressions. At the same time, his difficulty breathing highlights his deterioration. The doctor explains for the viewer that it is heartbreaking to lose people, and while medical technology can provide hope, aggressive interventions, such as sedation due to intubation, can also dehumanize and further isolate the patient at the moment of their death. In the last image we see of Brian, he states: "Whatever will be… it's okay" (Teitler, 2021). These last words can hint at his desire to avoid a medicalized death, but just as well to his trust in healthcare professionals to make the right choice, and such, these words can also hint to willingness of letting go of agency.

While *Covidland* brings forward how ICU technology has helped to save patients from acute illness, even these kinds of COVID-19 documentaries include critical views toward medicalization of death. Similarly to *Extremis* and *Facing Death*, *Covidland* refuses to turn to the trope of heroic recovery stories; instead, medicalization processes appear in all these ICU stories as temporary for patients with the potential to get through aggressive care, not as something that can eliminate death. The films' "being-toward-death" orientation represents deaths of patients as inevitable, even when stories include insights into challenges of making (right) care choices. Thus, the benefit of hindsight invites viewers to criticize medicalized practices, and in many cases, ventilators appear as a dehumanizing option for person-oriented care at the end-of-life.

## Hospice Documentaries and the Last Breath

Documentaries about hospice and palliative care erase almost all traces of medicalization. Occasionally these films show how patients are provided with medication or additional oxygen—but high-tech machines, such as ventilators, are missing from the narratives. In these films, agency is connected to breathing, yet the question is what time is left, not what a machine can provide. In the context of hospice, time arguably has special meaning because comfort care aims to appreciate the time that is left when one is faced with the lack of a future (Pasveer, 2019). In the Australian documentary *Love in Our Own Time*, the family of Jutta (the dying patient) talks about her breathing. Her daughter wonders: "She is lying there, breathing, but who

is she, where is her personality?" Here, the patient's weakening consciousness and presence are connected to bodily functions, such as breathing, and while it anticipates the imminent loss, it is also comforting, as the husband confirms: "the only movement is the breathing … that is a good sound" (Murray & Hetherton, 2011). Here, the role of breathing is directly connected to the dying process.

In these films, breathing is used to give updates on how each character is doing. For example, in the Canadian documentary *Dying at Grace*, situated in the palliative care unit at Toronto Grace Health Centre, the camera peeks into the patients' rooms to show and listen to them still breathing. Carmilla is the first patient to die, and her death is shown in a sequence at night. She is surrounded by concerned family, who witness her labored breathing, while a lightweight nasal cannula helps to increase oxygen flow. After the family leaves, the camera visits Carmilla's bedside a few times, together with nurses who are doing their rounds. The first time, a medium shot shows Carmilla's chest moving with the rhythm of each hard breath. The second time, a close-up of her hollow face cuts to an extreme close-up of her hand resting on her moving chest before returning to a close-up of her terminal breathing. The last scene of Carmilla is after her death. In the middle of the night, in a medium-long shot, the camera shows two nurses entering the room. They check her breathing, and when they cannot detect it, they take away the tubes and caress her skin. With one last close-up of her now immobile face, a voiceover shares a nurse calling Carmilla's daughter and telling about her very peaceful death. In this sequence, the troubled sound of breathing and the close-ups of the breathing body communicate aliveness as a contrast to the stillness and quietness at the end. Also, close-ups invite the viewer near to the dying person, creating a visceral impact.

In the hospice documentaries, the spatial aspects of breathing are empathetically visceral. The breathing bodies evoke embodied connections to the materiality of dying bodies, and because the embodied breathing invites consciousness of mortality (Fahd, 2019; Quinlivan, 2012), these moments invite viewers to experience the temporality of life. The sections of the films where the main characters' breathing is easier tend to include medium shots and medium-long shots that introduce the hospice space and people in it. When main characters' breathing gets difficult, the camera comes closer. In the deathbed scenes, the filmmakers tend to use medium close-ups and close-ups of dying people, creating a sense of intimacy. By bringing the camera, sometimes even a handheld camera, close to the dying person, the films leave no escape route and give no potential for distancing oneself from the moment of death. Particularly when there is no medical technology that stands in the way of gazing at the dying person, the access is immediate and affective.

Affectivity is emphasized in *Dying at Grace*'s closing scene, where Eda dies in front of the camera. The scene lasts for almost three minutes with a hand-held camera shooting a close-up of her face resting on the pillow. Her eyes are half-closed, her every breath difficult, gasping, almost as if it were an automatic, unwanted action. The breathing is visible through her slightly open mouth, movements of the cheeks, a slight bobbing of the head, and often difficult swallows. The sound of her difficulty breathing, or the death rattle, diminishes all other sounds. Breathing as the main visible and audible element in the scene invites the viewer to become aware of their own breathing, to compare their body with the dying body. This consciousness makes the viewer pay attention to the automated process of breathing, its rhythm, and its necessity for the lived experience and for continuation of inner, embodied time. The long-shot duration, hand-held yet rather immobile camera, and close-up of Eda's difficulty breathing emphasize the witnessing of the delicate moment of the last breath. During the scene, the gasps and gaps between breaths

increase, interspersed with silence, until there are no further breaths. When Eda stops breathing, the sound of the background noises returns, and the beeping sound from medical technology can be heard; yet at the moment of death, the focus is on the person, Eda.

In other deathbed scenes, the role of the last breath and the absence of medical technology are similar, highlighting the embodied, even natural process of dying. In *Love in Our Own Time*, the sound of dying is mixed with labored breathing from childbirth. In the montage, two women in labor use different breathing techniques to help with the pain, and these sounds are edited together with the death rattle of Jutta. The sound comparison continues even after the women have given birth and Jutta has died. From the sound of the new mothers crying with happiness, the film shifts to the sounds of desperate crying; soon viewers are shown how Jutta's family is crying around her deathbed. As Greene (2016) reminds, the sound of breathing draws attention and this conscious choice in cinematic narration always carries cultural meanings. In the case of *Love in Our Own Time*, the comparison between the defining moments of birth and death reflects the cyclical pattern of life. The first and last breaths become the same, yet different, highlighting individual experiences as part of nature, marking death as a natural instead of medical phenomenon.

While hospice documentaries focus on the person and the natural aspects of dying, the narration turns away from the promises of medical technology and the medicalization of death. However, at the same time, another aspect of technology comes to the fore—the role of cinematic technology. The ethics of filming the last moments of people highlights the camera's role as a witness, the filmmaker's and viewer's motivation to see death, and the medium-related relationship between the viewer and the dying individual (M. Gibson, 2001; Sobchack, 2004).

Sobchack argues that the typical cinematic choices in deathbed scenes—the carefully framed, focused, long, slow, immobile, and intimate images used in Eda's deathbed scene—indicate planning and permission to film death, and as such they serve as a promise of the "humane gaze" (Sobchack, 2004, pp. 189–191). Instead of peeking quickly from the door, the camera stays with the dying person, allowing the viewer to see the dying process in detail. While these moments highlight the responsibility of watching and permission to see, it also relates back to the questions of modernization and technology, where film technology is used to visualize, or even standardize, different situations in the medical field. The humane gaze creates expectations of what dying looks like, even if these often represent calm and peaceful deaths, and thus marginalize other experiences.

In addition to questions of spatial framing, time adds another level to the filming of deathbed scenes. *ISLAND*, a British documentary about Mountbatten Hospice on the Isle of Wight, includes an immobile seven-minute-long take of Alan's death. Grønstad (2016, pp. 119–135) argues that similarly to intimate images, a long take also emphasizes films' ethical potential because it minimizes dramatization, emphasizes hyperrealism, prioritizes atmosphere over action or speech, and spatializes duration by visualizing the passing of time. Indeed, because slow, or sometimes still, images contradict the cinematic preference for movement, they are powerful moments (Remes, 2012, pp. 259–261). When deathbed scenes slow the tempo and rhythm of a film, they highlight the importance of the moment and ethical connection with the dying person.

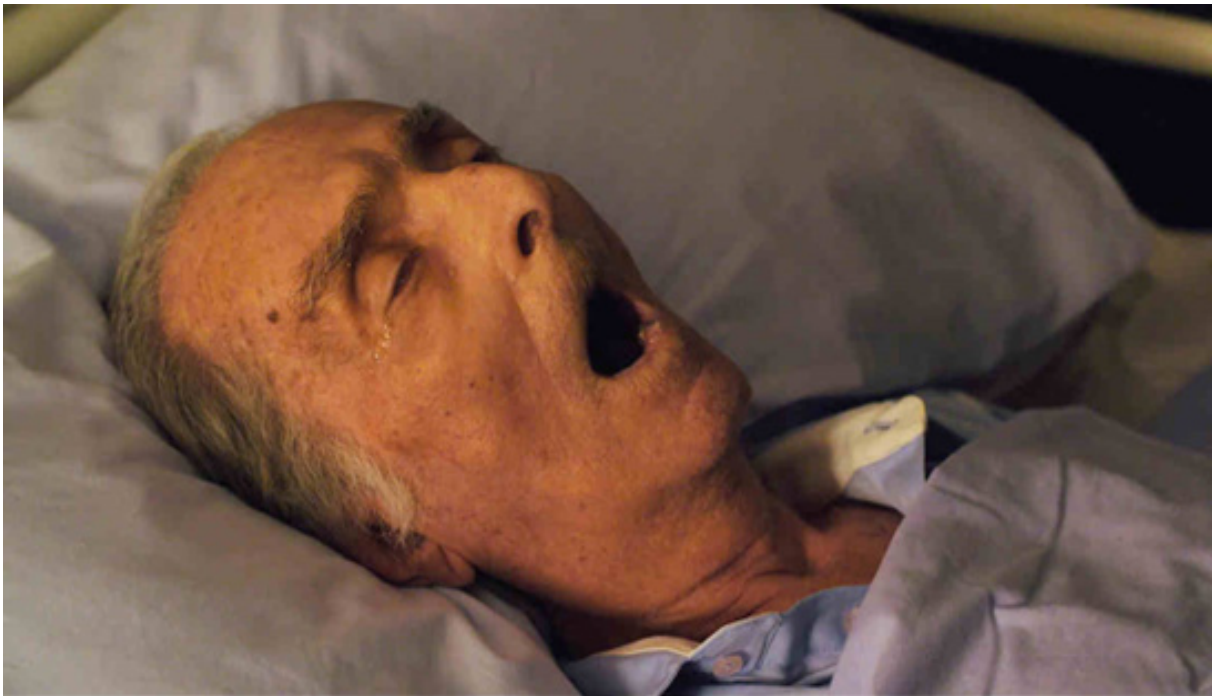

**Figure 1** *Death scene of Alan in ISLAND* (Steven Eastwood, Hakawati, 2018).

Similarly to Eda, small movements record Alan's breathing and gasps in breathing. Many times, he appears to have taken his last breath, just before he gasps for more oxygen. Alan's last breath finishes his participation in the world, even though it is difficult to pinpoint the definite moment of death. The viewer keeps waiting for the next breath, and the moment of death can only be recognized after it has already happened. This makes both embodied time and life fluid, as presence mixes with having-been and coming-forth.

After Alan's last breath, when his gasps stop, only non-movement and silence remain. The image and the body stay still until the nurse comes into the room and notices that he has died. This combination, silence and non-movement, pinpoints not only the death of a person but also a transformation in embodied time. When both movement and sound stop in the image, the film does not end. The frames continue to roll even if nothing changes. In these moments, the film makes a spectacle out of stasis, non-movement where only time continues. This use of stasis emphasizes time as an essential element of embodied film, and as Remes argues, perhaps even more so than movement, because even if nothing apparently happens in the image, the viewer witnesses as time goes by and this witnessing creates a constantly evolving experience (Remes, 2012, pp. 263–267). In Alan's case, the long take by his deathbed invites embodied connection, and after his death, the continued use of stasis helps the viewer to recognize the loss. This recognition redirects the awareness of Alan's embodied time to the viewer's embodied time. During the moments when the viewer realizes that Alan has died, the viewer also recognizes the continuation of life around him. Universal time moves on, and when the nurse enters the room, and action re-starts, the focus readjusts to those who remain, to the world and to the viewer that reacts to the death of Alan. This highlights how film moves on and time continues for others.

The moment of death can be challenging for an embodied connection to film. Sobchack argues that cinema has difficulties to reach the transgressive moment of death because embodiment takes place between lived-body subjects. The corpse, which is an inanimate non-

being, cannot invite this kind of active embodied connection, and as such, the humane gaze for so-called natural death "does not so much represent death as it represents the living of the process of dying" (Sobchack, 2004, p. 189). Thus, according to her, death as an event remains unreachable for cinematic technology. However, I argue that because of the ambiguity of the moment of death and the difficulty to pinpoint the exact end of (Alan's) embodied time, there is also fluidity in the viewer's embodied connection to the dying person. Thus, the subtle use of breathing can potentially transcend the limits between being and non-being in film narration. The viewer is allowed to co-experience the situation, if not death itself, and as such, breathing provides unique potential for cinematic technology to connect the viewer not only to what death is as a (medical) process but to what it might be as an embodied experience.

## Conclusion

While the totality of the multisensory dying experience remains out of reach of the cinematic apparatus, breathing is one way of narrating mortality. In the end-of-life documentaries, breathing addresses a sense of mortality not only through space, where the breathing bodies are given attention and various images and sounds of breathing repetitiously fill the screen, but also through time. "Being-toward-death" and the temporal fluidity of images of breathing (and non-breathing) characters highlight the sense of mortality and the embodiment of mortality. Consequently, this embodiment becomes connected not only to a breathing body as a spatial or material element but also a body as a temporal element in the narration. In the ICU films, medical technology and its criticism come to the fore. The spatial marginalization of the patients and borrowing time through medical devices override or reduce the agency of the patients and dehumanize their dying. In the hospice and palliative care films, being-toward-death is embraced, and the embodied time of the dying people provides potential for an intimate connection with the dying person, which in turn serves to humanize the dying process.

In these documentaries, breathing exceeds the sensory limitations of the cinematic narration and creates a powerful death-related experience. Thus, breathing becomes more than a physical or medical means to observe dying as a process; it can have a significant cinematic function to create embodied narratives about mortality. The represented images and sounds can affect viewers, and consequently, our bodies and understandings of bodies become altered by cinematic reproduction. The viewer can use the representations of dying bodies to gather knowledge and experiences of dying and death, including questions of the medicalization of death. Through criticism of overusing medical technology and by providing intimate connections with natural deaths, the 21st-century documentary films have challenged cinema's tradition of supporting modern medicalization processes and goals.

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