When cameras capture violent death, the backgrounds against which they do so are variable: a bustling street, a battlefield, a police station hallway, a train platform, and so on. With natural death, spatial possibilities close down. There is one iconic place where almost all lives end from disease or age on camera, in either fiction or documentary: the deathbed. Douglas Sirk’s *Imitation of Life* (1959) offers an archetypal deathbed scene, familiar from so many Hollywood melodramas. In the film’s closing moments, wealthy white actress Lora is summoned to the bedside of her beloved African American friend and housekeeper, Annie. A sentimental score plays throughout the scene in Annie’s bedroom, where people gather: Lora, close family friend Steve, Annie’s minister, her doctor, and another servant. The doctor listens to Annie’s heart with a stethoscope and shakes his head gravely to Lora, who becomes distraught.
Annie herself is ashen and fatigued but propped up in bed and alert. Animated by important tasks at hand (“I’ve got to talk, I’ve got to!”), she puts her affairs firmly in order: Annie instructs Lora and Steve to find her estranged daughter, Sarah Jane, and deliver her substantial inheritance and Annie’s apology for her perceived failings as a mother. Careful not to forget anyone, Annie bequeaths a pearl necklace to Lora’s daughter, a mink scarf to the minister’s wife, and a “nice, clean fifty-dollar bill” to the milkman at Annie and Lora’s old apartment (to whom, Annie reveals, she has been sending money every Christmas, “in both our names”). She directs Steve to a document in which she has fully planned her funeral, then gently ignores Lora’s desperate protestations that Annie won’t be dying for a long time. Head drooping and eyes closing, Annie says her last words: “I’m just tired, Miss Lora—awfully . . . tired . . . ” As she trails off, Lora’s panicked reaction confirms what we already know from conventions established by so many fiction films: Annie has just died.

The opening scene of the documentary Silverlake Life: The View from Here (1993, Tom Joslin and Peter Friedman) responds directly to this model of on-screen death and the way it has shaped Americans’ expectations for their own deaths and those of their loved ones. The film chronicles the physical deterioration and eventual death of its HIV-positive codirector, Tom Joslin. Living with AIDS himself, Tom’s partner, Mark, speaks in the first moments of the film, interviewed well after Tom has already died. Describing what he did immediately after Tom’s death, Mark explains, “I wanted to close his eye, because it’s very strange seeing a dead person staring, and I tried, just like in the movies, to close the eyelid. It doesn’t close—it pops back open! As I said to Tom, ‘I apologize that life wasn’t like the movies.’”Already having seen through Tom’s dying process how little death is “like the movies,” Mark feels renewed surprise that even this small detail—the ritual of closing the dead’s eyes, restoring some sense of peaceful slumber—has been a fiction.

Mark is typical of late twentieth-century Americans in his reliance on fiction film as a guide to what natural death is like. He continues this cultural recourse to fiction in the absence of personal experiences with the dying process (although many gay men of the late 1980s were quickly accumulating those), a recourse that suffuses much of twentieth-century history in the West. As early as 1915, Sigmund Freud remarked on the culture of death denial that he perceived (in Europe): “So we have no option but to find compensations in the world of fiction, in literature, in the theatre for that which we have lost in life.” Such a reliance is necessitated by two factors: mainly, the twentieth century’s well-documented removal of actual death from the public eye, but also
documentary’s sluggish response, its failure to rally against that removal and to project recorded dying onto American screens. Chapter 1 detailed the quest to capture, in photographs and on film, violent “moments of death” in a documentary mode—a quest that has proceeded without interruption since the mid-nineteenth-century invention of photography. By contrast, natural death (or its corpses, at least) had documentary exposure in the first few decades of photography through postmortem mourning photographs but virtually disappeared from the public eye during the twentieth century. Writing in 1974, just two years before Michael Roemer’s Dying would air on PBS, Amos Vogel identifies the extreme paucity of documentary work on natural death: “Although [documentarians] have already documented large areas of human activity and visited all the forbidden places in the world with their light-weight cameras and portable sound, their curiosity, with hardly an exception, has stopped short of death, funeral parlors, morgues or morticians. . . . That this entire area—more universal by far than others covered ad nauseam—simply does not exist in contemporary cinema, reveals taboo in its purest form.”

Violent deaths in fiction film (and occasionally documentary) may have provided a release for anxiety and curiosity about death during an era of its pervasive denial, but they did so at a remove from the way most American viewers’ lives would actually end. In my view, instead of serving a true memento mori function, these highly mediated images of violent death helped to repress awareness of the natural deaths awaiting most Americans (most by a wide margin: only about 7 percent of annual U.S. deaths are by violent means). And fiction film’s typical deathbed scenes—especially midcentury Hollywood’s—were misleading in preparing Americans to witness or experience these deaths, as Mark’s story demonstrates. Such scenes present many points of disjuncture with likely reality, as exemplified by Imitation: the nostalgic representation of death at home in an era dominated by hospital death; the appearance of reasonable health in the final hours; the absence of dementia, disorientation, or unconsciousness. Robert Kastenbaum labels this popular convention “healthy dying,” free of apparent symptoms. Most of all, fictional deathbed scenes tend to tailor death’s duration to narrative (rather than realistic) dimensions, allowing the audience to feel as if the full length of the death has been made visible to them. The process of dying is condensed so that a character like Annie, who had been vaguely ailing for a time from an unidentified malady, seems to become a terminal case just minutes before her clearly identified “moment” of death.

Fiction film’s deviations from the attributes of actual dying may reflect the difficulty of their representation as much as any desired distance from realism.
As noted in chapter 1, a slow and natural death in bed is an inherently uncinematic sight, bereft of the physical motion that defines the medium’s “moving image.” Vivian Sobchack emphasizes this difficulty in her foundational essay “Inscribing Ethical Space” (1984) through its ten propositions about death in documentary. Propositions two through four draw out the ways in which a violent and abrupt cessation of motion provides “the most effective cinematic signifier of death in our present culture.” Sobchack elaborates: “Death can only be represented in a visible and vigorous contrast between two states of the physical body: the body as lived body, intentional and animated—and the body as corpse, a thing of flesh unintended, inanimate, static.” As the deathbed documentaries discussed in this chapter make clear, the “lived body” on its deathbed is rarely “intentional and animated” as the time approaches when it will become a corpse. Between these two states, there is no “visible and vigorous contrast,” hence the need for what Scott Combs terms the “registrant”: an on-screen witness who will confirm that death, not always visible to the audience, has occurred. Registrants can be human beings—the doctors with their stethoscopes in Execution of Czolgosz, Lora with her horrified expression in Imitation of Life, the film characters Mark remembers who close the eyes of the corpse—or even, in recent decades, machines. With the advent of EKG and EEG monitors, cinema could rely on machine registrants in hospitals to substitute for the “visible and vigorous contrast” Sobchack describes: though the body remains still before and after death, the lines on the monitor jump around and then flatten.

If the gesticulations of an electronic line on a small monitor seem a poor replacement for violent death’s spectacle of movement, that lack speaks to something almost masochistic about moving image-makers’ attempts to document natural death. Ontologically, their medium aspires to embody movement—with film hiding the inherent stillness of its frames in the apparent motion of its projection. The drive to display natural death, then, careens toward exposing the medium’s own failures in the face of such a powerful metaphysical event. The camera will not be able to show death “in full detail,” to show the invisible physicality of it that would not register even if the lens were to penetrate the body itself. Buried in this effort to reveal death, is there an impulse to admit to what the moving image cannot do? To let it confront a phenomenon “beyond representation” and lay its limitations bare?

Answers to these questions are complicated by a fascinating deviation from film and photography’s quest for the violent “moment of death” when documentary once again takes up the challenge of representing natural death, as it had in the mid-nineteenth century through photographs. These deathbed
documentaries seek to make natural death newly public and visible in an era when it had become intensely private and invisible. And yet, the “moment” of death that would presumably read as a disappointing failure of moving image technology is simply absent from almost all of them, remaining private. This absence continues even in the deathbed documentaries that seem to directly promise access to that taboo sight, as in Showtime’s six-episode documentary series *Time of Death* (2013). Its title references the medical practice of declaring a precise “time of death” for each patient—a bureaucratic protocol that tries to make official the existence of an identifiable “moment” of death. Despite its title and advertising as a series that will take an “unflinching, intimate look” at the deaths of eight people, the series repeatedly flinches at the “time of death.” Sometimes there is a gap in footage because the dying party or family members ask to keep that time private or because death happens suddenly without the cameras’ presence, leaving the viewer with only a screen of text declaring the time at which this subject died. But in other episodes, the show’s crew is present for the death itself but refrains from showing it “in full detail,” staying a considerable distance from the bedside or cutting away to loved ones gathered there.

The absence of the “moment” of death redirects attention toward dying as a process—a gradual transformation that carries on past death through the grief of survivors. Instead of grasping for the “moment” of death’s nonspectacle of spatial movement, I assert, these documentaries shift their focus to the temporal, seeking to make death’s “full detail” visible through *duration* as new image technologies vastly improve the form’s temporal capacities. Duration becomes central in these works’ attempts to fully represent death because as much as natural death contracts space to the deathbed, it expands time from a “moment” (or the illusion of one) to a prolonged process—a process that gets progressively longer with advancements in medicine. The stretching out of time, then, characterizes two histories of developing technology in the twentieth century that meet in the deathbed documentary: the histories of medicine and of moving images.

At a logistical level, honestly chronicling a long process of dying calls for equipment that can record many hours of material at little cost and can roll for long stretches of time. Offering a cheap and versatile alternative to film stock, video—and later, digital video (DV)—appealed to underfunded documentarians and enabled some people to become documentarians who never could have afforded to with celluloid. After initial (and often unsustainable) forays into documentary video by activist groups and local access TV stations in the 1970s, by the late 1980s documentary filmmakers were adopting video more
Documentarians of the 1980s and beyond could embark on deathbed documentaries because of technological developments, but they did largely because of cultural factors: new conceptions of death and dying in the United States, the massive wave of AIDS deaths, as well as trends toward subjectivity, psychological intimacy, and autobiography in documentary.

Among those new conceptions of the end of life was a subtle reshaping of the “good death” to accommodate the altered conditions under which Americans died in the late twentieth century and early twenty-first century. Departing from the step-by-step instructions for dying that the medieval *Ars moriendi* provided and from the universal stages of confronting mortality that Elisabeth Kübler-Ross introduced in 1969, the dominant version of the good death now rejects those one-size-fits-all models. It favors, instead, customized dying rooted in individuality, with each dying person laboring to design and achieve his or her own unique good death. This new good death aligns with broader cultural and social forces: with the emphasis on customization in media and consumer culture in the postindustrial era and with neoliberal mandates for the individual to be self-sustaining and to achieve maximum success in every pursuit. When death is meant to be a final expression of one’s unique personhood, the natural “moment of death” becomes a homogeneous obstacle to that expression. Conscious and alert right to the second when her body gives out, *Imitation of Life*’s Annie remains fully herself, personifying her unshakable goodness and distinctive spirit in her last moments. Most actual natural deaths, though, do not allow for such individuality at the end, as body and mind take leave of life asynchronously. When the mind shuts down before the body, the perceived “moment of death” becomes terribly conventional, erasing individuality as unconscious and often emaciated bodies labor to breathe and then stop breathing.

Because it is misleading as a representation of the long process of dying and because it is neither cinematic nor individualized, the “moment of death” so sought after by documentarians capturing violence becomes taboo in documentaries of natural death. By leaving it out, deathbed documentaries bolster a recent fantasy of dying as a fully individualized affair. But, I argue, by leaving it out, they also use the innate strengths of new technologies to expose and reject the temporal fantasy of violent death documentary: that death is a sharp *moment* of transition that cameras can make transparently visible, rather than a prolonged process resistant to cinematic representation. Thus, just as video and digital technologies enable cameras to wait for death, to be finally “on time” in meeting it, documentarians willfully turn those cameras off.
The twentieth century’s widespread culture of death denial in the West (described in my introduction) arrived alongside the hypermedicalization of death as it moved from the home to the hospital in the early to mid-twentieth century, sharply altering the nineteenth century’s dominant vision of “beautiful death” as a romantic and temporary parting. As the nature of the “good death” was evolving, this hypermedicalization also brought new fears of bad deaths. As historian Philippe Ariès articulates: “The death of the patient in the hospital, covered with tubes, is becoming a popular image, more terrifying than the transi or skeleton of macabre rhetoric.”

This frightening style of high-tech, modern hospital death is hardly the sort that Annie experiences in *Imitation of Life*. In most respects *Imitation* presents a deeply nostalgic version of the good death that predates its 1959 production year. Unlike patients of the period in their sequestered hospital rooms, Annie dies—anachronistically—at home with loved ones gathered around her. She herself, not her doctor, directs how her death will proceed, giving instructions and telling those assembled when to keep quiet and listen. An inconsolable Lora tries to persuade her that she won’t die for a long time, but Annie refuses to participate in this twentieth-century denial and maintains focus on her impending demise. In keeping with long-established spiritual expectations of Western dying, she shows concern for her soul’s fate, affirming, “I’d like to be standing with the lambs, and not with the goats, on Judgment Day,” and demonstrating goodness through her carefully selected bequests and kindness to the old milkman. Annie wraps up her affairs and has planned her own funeral so as not to burden her survivors, for whom she provides. In a moment reminiscent of nineteenth-century beliefs that approaching death would give wisdom to the dying that they could share with those assembled, Annie sagely tells Lora, “Our wedding day and the day we die are the great events of life.” And in keeping with the importance of deathbed attendance in the nineteenth century, she registers the tragedy that she cannot say good-bye to her estranged daughter, Sarah Jane, whose absence looms through a large photograph on the nightstand. Lastly, Annie achieves death’s optimal duration, concluding earthly business and then promptly dying. She will make no trips to the hospital, will not be covered with tubes or punctured by needles, lingering for months; she simply closes her eyes and is gone. Between her nostalgic death scene and actual deaths at that time—between even the nineteenth and twentieth centuries—there is, as Ariès remarks, a reversal as complete as that of a photographic negative.
In the late 1960s, the previous decades’ “brutal revolution” of modern hospital dying that is pointedly not pictured in *Imitation* began to generate significant backlash in the United States—a backlash that would later include deathbed documentaries. Doctors came under criticism in “a diffuse rebellion against the medical dictatorship . . . partly spiritual and partly secular.” The spiritual and secular elements of this rebellion shared a common goal: to redirect attention from the body of the dying to her personhood (whether through psychology or the soul). Leading the charge was Dr. Elisabeth Kübler-Ross, a Swiss-born psychiatrist who sought to rehumanize end-of-life care with her book *On Death and Dying* (1969), best known for its five stages of psychological reactions to the news that one is dying. According to Kübler-Ross, patients will first experience denial and isolation, followed by anger at their diagnosis, then will attempt to bargain (with God or doctors) for more time, slip into a state of depression, and finally accept the fact that they are going to die.

Though revolutionary in its time, Kübler-Ross’s *On Death and Dying* also marks a return to the idea of an instruction manual for death—an idea at least as old in the West as the medieval *Ars moriendi* (*The Art of Dying*), a tract of monolithic, Christian guidelines for the dying that focused on the soul’s fate and shaped that era’s notion of the good death. Both impose a structure onto the dying process (Kübler-Ross’s five stages, the *Ars moriendi*’s five temptations) that has nothing to do with medicine and the body, describing a fierce battle in the mind of the dying that promises a psychological or spiritual reward: ending life at peace or ascending to heaven. Like the *Ars moriendi*, *On Death and Dying* embraces the spirit of the memento mori, affirming, “We should make it a habit to think about death and dying occasionally, I hope before we encounter it in our own life.” Both of these pieces of writing and the later deathbed documentaries serve as aids to death’s contemplation and as potential guides to achieving the good death—sometimes explicitly announcing this latter function, as in the pointedly titled *The Art of Dying*.

Interestingly, at the time when Kübler-Ross was recentering death into the mind of the dying on a psychological level, doctors were doing the same on a physical level. The innovation of heart transplants in 1967 had heightened simmering moral and medical debates about when a patient becomes “dead.” Patients who were biologically alive but unlikely to regain meaningful consciousness became important sources of well-oxygenated organs, but doctors removing their still-beating hearts needed a revised definition of death as protection from murder charges. Designating the “moment of death” with legal precision, though, was a fraught task. As an article published in the *Journal of the American Medical Association* in 1968 lamented, “It seems ironic that the
end point of existence, which ought to be as clear and sharp as in a chemical titration, should so defy the power of words to describe it and the power of men to say with certainty, ‘here it is.’” I have already asserted the difficulty of pinpointing that “moment” with cameras, but here were medical experts, with full access to internal biology, also unable to declare, “here it is.”

With transplants on the rise, legal and medical forces together pushed the brain to usurp the heart’s role as the single-organ linchpin of human life. Under the new status quo, “In order to be dead enough to bury but alive enough to be a donor, you must be irreversibly brain dead.” Coincidentally, this move from heart to brain dovetails with Kübler-Ross and others’ focus on the individual in death, with the brain conceived of as the organ that contains unique personhood. Doubts lingered, though, about the besieged theory of life and death as “unequivocal, dualistic categories” governed by a single organ and divided by a distinct moment. These doubts surface periodically through high-profile patients in hotly disputed “brain-dead” states, such as Karen Ann Quinlan, Nancy Cruzan, and Terri Schiavo. As Margaret Lock concludes, “Clearly, death is not a self-evident phenomenon. The margins between life and death are socially and culturally constructed, mobile, multiple, and open to dispute and reformulation.”

Between death’s aggressive medicalization in the twentieth century and the redefinition of its boundary with life, we see the “moment of death” that seemed so clear to chapter 1’s image-makers further destabilized by a prolonged process of dying whose end point is not completely evident.

One can understand Kübler-Ross’s impulse to provide temporal structure to this sprawling and ill-defined process through her five stages. Her work was both warmly embraced and fiercely criticized in the United States, exposing a passionate concern about the country’s deficient death culture but divided opinions on how to improve it. The ensuing decade saw a flurry of discourse on the end of life: books and articles, college classes, support groups, and the emergence of hospice and palliative care as alternatives to Kübler-Ross’s chilling vision of typical hospital dying. These seeds of change planted in the 1970s grew into a modest movement that continues into the twenty-first century. Its proponents are united by a core belief: that dying people get lost amid the hospital’s network of tubes, lines, and machines, the barrage of treatments intended to save their lives, doctors and nurses attuned to bodies but not to emotions, and family and friends unprepared to discuss approaching ends. Thus, the writers, teachers, and caregivers involved in what Tony Walter calls “the revival of death” work to individualize dying, transforming it from a cold medical routine into a process undertaken differently by each unique human being. As Larry Churchill put it in 1979, “nobody dies by the book”—an implicit rebuke.
of On Death and Dying, which had been the book for the past decade. Now an ambivalent figure for the movement, Kübler-Ross had redirected attention to the personhood of the dying but had also collapsed end-of-life experiences into a rigid, step-by-step formula meant to apply to everyone.

The new movement criticized the reigning model of death in the United States but also sought once again to reshape the good death, working toward what Kastenbaum terms a nova ars moriendi. Begun in the United States in the early 1970s, the modern hospice movement has been the greatest force in this endeavor, providing an alternative to hypermedicalized death and inspiring palliative care programs within the medical establishment. Prioritizing meaningful and low-pain dying over painfully prolonged living, hospice offers death at home and also greater attention to the patient’s psychological needs. Kastenbaum, who was personally involved in its early years, describes the organization with its own characteristic rhetoric, revealing its alignment with the nova ars moriendi’s neoliberal emphasis on individuality: “The terminally ill person’s own preferences and lifestyle must be taken into account in all decision making. . . . Hospice patients and their families were not placed on a conveyor belt for the assembling of a standard-issue death.”

The variety of deaths hospice actually provides may not be as wide as its rhetoric of unique death implies, but the promise of a customized experience—matching the American focus on choice in consumerism—has helped the movement grow. Approximately 45 percent of U.S. deaths (from all causes) now happen under hospice care. Hospice is part of the significant (but not culturally dominant) push to acknowledge dying as a process too long to disregard and long enough to potentially experience meaningfully. Finally abandoning the idea of death as a problem that can-do American determination will overcome—a tantalizing hope in the heady years of the early twentieth century’s rapid medical advancements—the culture has turned toward other national values, making death a locus for individual expression and consumer choice.

In this way, the new good death still follows a key principle by which it has been revised throughout history: the good death embodies a given society’s highest values. In recent decades, it has come to embody a number of disquieting neoliberal values. These underlie the apparently progressive nova ars moriendi in its focus on the individual and her personal responsibility to craft her own good death through active choices. As Wendy Brown writes, neoliberalism “figures individuals as rational, calculating creatures whose moral autonomy is measured by their capacity for ‘self-care’—the ability to provide for their own needs and service their own ambitions. . . . The rationally calculating individual bears full responsibility for the consequences of his or her
actions no matter how severe the constraints on this action.”

Even when that constraint is biological (the impending end of life itself) rather than socio-economic, as Brown envisions, neoliberal subjects are conditioned to succeed, to achieve—to succeed at dying well, to achieve the good death. Doing so compensates for the subject’s (eventually inevitable) failure to optimize her own health—what Nikolas Rose describes as her obligation to successfully manage risk by acquiring health knowledge, continually monitoring her own body, and actively making healthy choices.

In other words, while the ideal neoliberal subject safeguards her health in order to remain a productive, consumptive being, there are still ways in which her death—once it becomes unpreventable—can align with neoliberal values.

The neoliberal rhetoric of this nova ars moriendi grounded in individualism and productive choice is everywhere apparent in discourse on death. In scholarly work, Walter notes that “in a culture of individualism that values a unique life lived uniquely, the good death is now the death we choose”; Carlo Leget asserts, “We have become very sensitive to the unique wishes of each authentic individual” in death; and Ernest Becker frames the end of life as the last opportunity for individuals to discover and express their true selves.

Extensions of this idea in the popular press sometimes take a tongue-in-cheek tone, as in a self-help book called *To Die with Style!* (1974) or the infamous Timothy Leary’s *Design for Dying* that posits “Designer Dying” as “the hip, chic thing to do. . . . Even if you’ve lived your life as a complete slob, you can die with terrific style.”

In a culture increasingly framing death as individualized, a call has also sounded to gather and share those unique experiences. Voiced by many writers, this call for “stories over stages” (as Churchill puts it, referencing Kübler-Ross’s five stages) implicitly holds hopes for both the dying and the living: that talking about their situation will be liberating to the dying, and that having examples of the nova ars moriendi will help the living plan for their own good deaths.

Here we arrive at the function of documentary in this complex culture. Deathbed documentaries oppose the fetishized “moments” of violent death that other documentarians have pursued, the “standard issue” death that has characterized modern hospital dying, and even the equally standardized steps away from that model that Kübler-Ross took. Instead, they tie together many strands of post-1960s U.S. death culture: they tell the personal stories death scholars have called for, challenge the centrality of the “moment of death” by excluding it in favor of the long dying process, and model the nova ars moriendi with a focus on highly individualized dying. Indeed, this individualization trend complements not just the era’s death culture but also its media culture, as the rise of video and then digital production and distribution.
afforded opportunities for smaller, personal projects and more customized audiences.

These technological affordances of video and pv, and the deathbed documentaries they enable, also engage with the nova ars moriendi’s neoliberal elements. Anthony Giddens stresses that the subject in the age of neoliberalism must be ever-focused on self-identity, which “has to be routinely created and sustained in the reflexive activities of the individual.” These “reflexive activities” can incorporate a drive toward self-improvement (including in caring for one’s own body) and a continual, introspective evaluation and narrativization of one’s choices (including one’s choices in how to die). By watching a documentary tracking the successful—or instructively unsuccessful—deaths of others, the neoliberal subject potentially gathers resources to prepare a death of her own that will express her unique personhood. By making or participating in a documentary tracking her own death, the neoliberal subject publicly articulates her well-crafted self-identity through her customized good death.

Despite the warmth of its rhetoric and its many appeals compared with midcentury hospital dying, the neoliberal nova ars moriendi’s emphasis on individual self-identity—and the highly individualized death documentaries that help shape it—can undercut the power of shared experience and the memento mori. In the Ars moriendi or Kübler-Ross’s stages, we are all equally implicated. Similarly, many of the skeletons who shadow the living in traditional memento mori iconography are stripped of identity, mere bones; they could be anyone, which is partly the point. Not so in documentary chronicles of avowedly unique dying. Rather than prompting a hard look ahead to our own future deaths, these films may instead allow a damaging distance between the viewer and the dying—offering an implicit (and likely unintended) assurance that since I am so different from this singular human being on-screen, this documentary is not previewing the death that awaits me. The films may thus become tools of disassociation, allowing a gaze at the death of another without the burden of identification.

There are other troubling elements of this video corpus, too: the death stories told through documentary tend to focus on a narrow range of subjects, demographically speaking. The dying people featured in these documentaries are men more often than women, white more often than of color, and middle or upper class more often than working class (sexualities and gender identities outside U.S. norms, by contrast, are strongly—even disproportionately—represented). These trends match similar problems in scholarship on U.S. death culture, and the sense in which death’s naively touted universality usually comes back to the deathbed of this dominant version of the Everyman.
In fact, there are notable divergences based on identity in how individuals are likely to meet their inevitable ends. An African American male in the United States, for example, is about two and a half times less likely to die from natural causes—the type of dying portrayed in deathbed documentaries—than a white female. While the likelihood of violent death for an African American male remains low overall, its threat looms culturally larger for some such individuals (as Oscar Grant’s death, analyzed in chapter 4, illustrates) and may discourage them from identifying with “universal” deathbed scenes.\(^{36}\) I note this example of divergence along racial lines as a reminder that U.S. death culture is not monolithic and that my own assertions about the imbalance between violent and natural death in U.S. media do not carry the same psychological consequences for all audiences.

**A New Machine at the Deathbed: The Camera**

The first significant deathbed documentary to be made in the United States is less guilty of the offenses mentioned here than most that would follow it. Michael Roemer’s *Dying*—made on 16mm film (as discussed later) with support from the National Endowment for the Humanities and airing on pbs in 1976—strives to represent individualized dying through a representative range of U.S. citizens rather than one dying person. The filmmakers include footage of three terminal cancer patients in the Boston area, recorded over a period of five to six months each: Sally, a forty-six-year-old white woman; Bill, a thirty-three-year-old white man, married and with young children; and Reverend Bryant, a fifty-six-year-old African American grandfather.

Sally’s segment comes first, showing the woman in her room at a medical institution.\(^{37}\) Her head has been shaved, and she looks old beyond her years. She speaks directly to the filmmaker, reporting that she has a brain tumor, that there’s nothing that can be done for it, and “All you have to do is wait.” And wait she does through a death of a languid, slowly unfolding duration. That duration resonates with the present tense of the film’s title, *Dying,* which underscores the idea of death as a process, not an event. Sally spends some time at this institution learning how to function in her somewhat debilitated body, joking with nurses and encouraging other patients, staring out the window as she listens to Beethoven. Then she moves home to the care of her elderly mother, where she spends quiet days watching her mother bake and listening to music while her mother knits. As these days of waiting stretch on, Roemer accelerates time with shorter and shorter chunks of Sally’s life as death seems to approach. In these scenes she moves from sitting in a wheelchair drying dishes to sitting
and being fed by her mother to lying in bed, seemingly unable to speak. The passage of time is signified through Sally’s body in two poignantly opposed progressions: her hair grows longer, and her motor functions shut down. Though Roemer’s editing seems to propel us in an orderly and measured way toward Sally’s death, its “moment” is not shown in the film and does not arrive in the time frame we expect. On-screen text informs us that Sally became comatose late in 1974 and died on June 24, 1975—two years after her initial hospitalization and at least six months after the last footage of her that Roemer includes.

The next segment, titled “Harriet and Bill,” begins with uncertainty as the title couple is shown in the waiting room of a doctor’s office, speaking with each other tensely. Harriet is visibly upset, but the next shot of Bill on an exam table lets the audience know that he is the one dying. The segment follows Bill and Harriet through their family routines: taking their young sons to the lake, having family meals, and going to medical appointments. Because the two are featured as a couple, one might expect this segment to center emotionally on death severing the bonds of romantic love. But that nineteenth-century model of dying is nowhere in evidence. Seemingly an even older lens for viewing death is in place, as Harriet reacts to Bill’s demise less as an emotional blow than as a disruption of social and economic life. She tells Bill’s doctor, “I would rather be left now, and then I would have a chance to maybe get them another father or something,” and she confesses, “I prayed that that chemotherapy wouldn’t work . . . if he’s gotta go, why can’t it just be quick and get it over with?”

The duration of twentieth-century dying that bothers Harriet features prominently—as it did in Sally’s segment—and once again the camera leaves well before death, with only on-screen text telling us its date. The last shot of Bill evokes fiction film’s model of “healthy dying”: appearing physically well, he reclines on a lawn chair in his yard, staring into the distance and ignoring Harriet.

Dying’s final segment observes how Reverend Bryant, an African American grandfather and pastor of a Baptist church, copes with terminal liver cancer. Roemer’s crew is with him when his doctor delivers the bad news. They record his momentary despair and his quick psychological recovery. Bolstered by religious faith, a loving family, and a deep sense of satisfaction about the life he has lived, Bryant speaks with Roemer about how he will proceed, knowing that he will die soon: “I don’t think that Rockefeller could be as happy as I am. I’m the happiest man in the world. . . . The time I have on the topside of this earth, I’m going to try to live it out the happiest and the best that I know how.” He decides to take a trip to the South with his family to see his childhood home and his parents’ graves, preaches a sermon on dying, then takes to a deathbed set up at home with family life bustling nearby. The now-expected
on-screen text informs the audience that Bryant died on January 23, 1975, but then the film proceeds with a long sequence shot at his funeral. As a choir sings and person after person walks past his open casket, affectionately touching his hands, Roemer ends *Dying* not with the title act but rather with mourning. This shift at the film’s end implicitly reflects cultural variations in “the good death,” taking up the greater emphasis placed on expressive mourning rituals in defining the “good” African American death—an emphasis often seen in media representations of such deaths, including Annie’s elaborate funeral that closes *Imitation of Life*.

Made in the mid-1970s, *Dying* is historically situated not only in a decade of death’s fierce “revival” but also in a period of transition for documentarians. In the United States, the style of direct cinema—enabled by smaller, lighter, and more versatile film and sound recording equipment—that felt so fresh in the 1960s was by that time experiencing significant revision and opposition (though many documentaries are still made in this style today). The documentary form was becoming invested in deeper explorations of its subjects’ psychologies and biographies than the “fly on the wall” production mode could easily achieve. On one level, then, a turn away from the physical and toward the psychological manifested in both death culture and documentary filmmaking during the 1970s. The most common manifestation in the latter was a willingness to let subjects acknowledge and interact with the camera and crew, especially in the increased use of interviews. Staying true to the basic observational mode that direct cinema exemplified, Roemer nevertheless felt free to defy the movement’s dogma. Not restricting himself to natural light, he warmly lit some scenes artificially; rather than playing the “fly on the wall,” he interviewed the dying to let them narrate their experiences directly (ideologically essential for a post–Kübler-Ross death culture that prioritizes speaking and listening to the dying). Interviews and warm lighting help Roemer frame most of the film’s deaths as good ones, disassociated from the aesthetic sterility and emotional distance—reminiscent of “bad death” in the hospital—that a direct cinema style can evoke.

Though the style may still have felt too detached for some (Ariès critiques *Dying* for “reducing [death] to the state of an ordinary thing”), the film garnered gushing reviews from critics. It provoked highly emotional responses, characterized by the reminiscences of Susan Kubany, an employee at WGBH, where *Dying* was produced: “I refused to allow anyone to watch ‘Dying’ alone. At last count, I had seen it 97 times, possibly more than any other person. Critics with whom I had had solely a professional relationship, sobbed in my arms at the end, close friends for having shared such an experience.” Though
it has limited distribution today, Dying outlived its initial PBS run and its reels were made available for the era's popular thanatology college courses, accompanied by suggested discussion questions.\textsuperscript{42}

Dying represents the entry of a new machine—the camera—at the deathbed, a site smothered by technology in the twentieth century. At that point, death's “revivalists”—especially in hospice and palliative care—were busily thinning the tangle of tubes, lines, and beeping instruments that surrounded the dying. They were reacting in part to a fear Kübler-Ross articulated: “We displace all our knowledge onto machines, since they are less close to us than the suffering face of another human being which would remind us once more of . . . our own mortality.”\textsuperscript{43} The documentary camera, though, is one machine that promises to reproduce and display the face of the dying rather than obscuring it—to carry its sign of “our own mortality” to wider audiences. But in another way, the camera is merely a stopgap in addressing this aspect of twentieth-century America's virulent death denial, for machines typically allow us to avoid two distinct aspects of the “suffering face” of a dying person: the face as sign, signifying death, but also the face as outlet for interactive communication. As Kübler-Ross emphasizes throughout On Death and Dying, there is an awkwardness and fear associated with actually talking to the dying—a fear that the camera indulges, letting us gaze as voyeurs at the “suffering face” without having to respond to it.

Regarding the documentary camera’s aptitude for contributing to a nova ars moriendi, there are two types of impact this machine can have. First, it can be a tool for the dying to use in assembling their individualized good deaths. Second, it can transmit their death stories to the living in the imperative mode of the memento mori or the instructive mode of the Ars moriendi. For the dying, the camera provides listeners through the crew and the documentary audience that its presence implies—outlets serving the philosophy of “expressive death,” whereby the patient must talk and be listened to in order to cope with the end of life (a sort of “talking cure” for the mortally incurable).\textsuperscript{44} That function is apparent in Dying with Sally, who has plenty to say and not many loved ones to say it to; with Bryant, who relishes the chance to take stock of his life verbally; and with the soon-to-be-bereaved Harriet, who uses the camera on multiple occasions to confess her desire for Bill's death. More than just a counselor or confessor, though, the camera also supplies Sally, Bryant, and Bill with an additional layer of temporal structure in the long and amorphous process that so defines modern dying. Overlaying five or six months of a documentary’s shooting schedule onto this process gives them appointments with people who are not doctors and a way to mark time other than through physical deterioration.
Reflecting on the production of *Time of Death*, executive producer Miggi Hood notes, “It turns out when you put a camera on someone who is dying, they keep going. It keeps them looking forward, it gives them a distraction from the inevitable.”

Further, the camera offers a sense of purpose to those who invite it to their deathbeds—a way to make a rote biological process *mean* something other than just “the end.” A sense of lost purpose makes dying a demoralizing experience in a culture that places such value on productivity and individual accomplishment. When Sally says of her brain tumor, “All you have to do is wait,” her “have to do” takes on two meanings: waiting is the only task she is assigned, and waiting is all she has—the only opportunity now extended to her. The purpose Roemer's film gives Sally is especially clear, as she seems to want to be remembered as someone who died well. The camera gives Sally a compelling reason to strive for that experience, to discover and embody her own good death. At times, she overtly performs the role of the irrepressibly cheerful and fearless dying woman, hamming it up as she jokes with the nurses or shouts carefully pronounced encouragements to another patient. While direct cinema tried to guard against this potential “acting for the camera,” Sally’s behavior is framed more accurately by the principles of the related documentary movement, cinéma vérité. Verité documentarians use the camera not as direct cinema’s invisible recorder but rather as a tool of provocation, helping authentic feelings and behavior to emerge that would otherwise remain hidden.

Even if Sally’s positive attitude looks a bit artificial, Roemer thinks of the film as giving her a reason to nurture it and to find enjoyment in the last portion of her life. *Dying* promises that her actions will travel beyond a small circle of medical staff and family, benefiting others who will one day find themselves in her position. As Combs elegantly writes of films in general, “The cinema wants to solve the basic problem of the loneliness of death, to mediate the event of someone’s death so that it communicates to the outside world.” As Sally’s case demonstrates, this project in documentary takes on a poignancy and an urgency it does not carry in fiction.

And what will the living—those for whom Sally performs—take from deathbed documentaries like *Dying*? How do these films contribute to the nova ars moriendi? At the most basic level, this initial documentary look at natural death seeks simply to make public what has been kept private in decades of cultural denial. In the memento mori mode, it offers an impetus to “think about death and dying occasionally . . . before we encounter it in our own life,” as Kübler-Ross advises. The film also presents two potential examples of the good death through Sally and Bryant, reflecting on some of its common features in
1976: both appear to die at home rather than in a hospital (aligning with the fledgling hospice movement), both acknowledge that their lives are ending and strive to make their remaining time enjoyable and meaningful, and both rely on family members for support.

Though *Dying* may seem instructive through its models of the good death, the film—and all deathbed documentaries—must contend with a tension inherent in the post-1960s nova ars moriendi. If the good death is now the individualized death, then the very notion of an ars moriendi becomes obsolete; the dying can neither rely on shared rituals and norms nor pattern their own deaths directly on others they have seen unfold (either in life or through documentary film). As A. H. Hawkins articulates, “Perhaps one reason why dying seems so difficult today is that individuals are expected not only to confront their own death—in itself a task arduous enough—but also to create a death” in a process I have aligned with neoliberal ideology. In this light, the good death we cannot replicate (Sally’s, Bryant’s) becomes perhaps less instructive than the bad death we can strive to avoid, included in *Dying*—I argue—through Harriet and Bill’s segment. Bill dies a “bad death” by multiple twentieth-century standards. Unlike *Imitation*’s Annie, he cannot master the timing of his exit. Harriet waits for him to die, anxious for it to proceed quickly, and the audience waits, as well, expecting to see his body start deteriorating. But Bill lingers in his illness and remains mostly healthy in appearance, resisting the “right” duration of dying for either his loved ones’ desires or the conventions of death in cinema. And by the new “bad death” standards of his own era, Bill fails to achieve the kind of individualized death that affirms his unique spirit. In *Dying*, he reads as a nonperson—a blank surface on which both disease and the desires and anxieties of others (Harriet) inscribe themselves.

Roemer himself, who wrote about *Dying* as being designed to help the living get past their fear of death, does not regard it as instructional in the next step, in how to die well. His remarks echo the spirit of individualized dying that was strengthening in 1976: “You can’t learn to die as though it were a skill. People die in the way they have lived. Death becomes the expression of everything you are, and you can bring to it only what you have brought to your life.” This quotation from Roemer, with its assertion that dying is “an expression of everything you are,” mirrors the emphasis *Dying* places on different facets of its title experience: specifically, that dying is more fundamentally about psychology and selfhood than physiology. In line with the 1970s death culture that reacted against previous decades’ tendency to focus on only the dying body, Roemer’s film favors the mind, striving to represent “dying in full detail” on a psychological but not physical level. Without hiding the body, Roemer nevertheless
de-emphasizes it, largely through timing. He excludes the “moment of death,” the climax of bodily dying, and even footage shot near the “moment.” Scenes that show the subjects in a state of heightened physical debilitation are few and markedly shorter than others—as if the story of dying is more or less told once the body’s deterioration usurps psychological and spiritual reflection. Only at rare moments in the film is the dying body displayed as a dying body in any graphic way. The most notable comes a few minutes into Sally’s segment when she happens to turn her shaved head to the side and exposes to the camera a sprawling, craterous indentation on her skull—presumably the site of a previous surgery on her tumor.

Instead of showcasing the dying body, Roemer prevents it from overshadowing the dying person—a challenging task in his chosen medium, which is so well suited to displaying the material world. Roemer’s desired emphasis is most apparent in a gorgeous close-up he creates of Bryant in an interview, as he passionately distills the value of his life and how he will savor what remains of it. The tight shot’s larger-than-life composition and warm lighting cinematically disconnect Bryant’s broad smile and still-vibrant eyes from the rest of his withering body. Disorienting us from where we are in the timeline of Bryant’s long process of dying, the shot grasps at timelessness. It enforces a focus on Bryant’s words—his feelings about his wife, his assertion of happiness—which transcend the blunt statement his unseen body, with its marks of illness, would make.

While critical reception of Dying was overwhelmingly positive, Stefan Fleischer’s harsh 1978 critique in Film Quarterly offers an important objection to the film’s mind/body priorities. Noting the psychological orientation of Roemer’s film, Fleischer protests, “But dying is not first of all a mental problem. The most brutal and the most inescapable fact about dying . . . consequently the fact most systematically repressed, is the nature of the physical process itself—pain, incapacity, and the withering away of flesh.” Fleischer supports his argument by selecting and disregarding parts of the film carefully, but the essay nevertheless exposes an interesting level of unrest in the fledgling death revival culture. Though the cultural context of Dying seems to align it smoothly with the rebellion against the body-obsessed, hypermedicalized death culture of the mid-twentieth century, Fleischer’s critique reveals an emerging backlash. He expresses a feeling that the pendulum had swung too far in the other direction, from obsession with the body to obsession with the mind. Moving into the 1980s and 1990s, with the dual influence of the AIDS crisis and the wide adoption of video and DV, deathbed documentaries would return to the body of the dying.
Before examining subsequent deathbed documentaries on video, it is helpful to consider the fact that *Dying* was shot on film and to ask how these media each enable certain kinds of documentary work on death. Though it changed production conditions more in degree than in kind, video has made a new relationship possible between death and the moving image. In the case of natural death, there are four main areas in which shooting death on video or *dv* instead of celluloid matters: cost, durational capacities, crew requirements, and aesthetics.

With a videotape (and its later *dv* variations) costing a small fraction of the equivalent reels of film stock, the former’s adoption by documentarians brought the price of projects down considerably. In this mode of filmmaking that has rarely attracted big budgets and box office returns, that change made a dramatic impact on the types of topics and approaches documentarians could pursue. The consequences of this price difference between film and video are plainly articulated by Ross McElwee, another documentarian experimenting with new forms and subjects during a period of technological transition. Of his meandering, autobiographical documentary *Sherman’s March* (1986), he writes: “I shot perhaps twenty-five hours of film [over five months]. I did not have a very big budget and had to marshal my film stock carefully. I sometimes wonder how much more footage I would have shot if I had been shooting video.”

The cost of film stock or videotape is an issue of particular importance for deathbed documentaries because of the length of the dying process. Illustrating this temporal challenge, for one episode *Time of Death* uses an automated *dv* camera mounted on a tripod to record its dying subject, Cheyenne, deteriorate at a glacial pace over the course of a whole night. Temporal markers flash on the screen during this sequence as Cheyenne’s girlfriend comes in and out of the room—10:18 P.M., 1:05 A.M., 3:32 A.M., 6:34 A.M.—and its time-lapse editing conveys just how long it can take for this last phase of the dying process to conclude. With Cheyenne’s “time of death” announced on-screen as 6:36 A.M., this sequence alone required more than eight hours of continuous recording. To chronicle death thoroughly, then—and to do so for multiple dying individuals, as *Time of Death, Dying*, and others do—requires a significant commitment of time and footage.

Further, this topic remains a hard sell, even among documentary enthusiasts. Writing favorably about *Dying*, Michael Kearl laments, “Such shows, how-
ever, are rare. The emotions and fears they evoke are too great, their exhibition
too ‘real’ for the comfort of their escapist viewers, to garner the viewer ratings
required to subsidize their production.” In his attack on Dying, even Fleischer
acknowledges that if Roemer had tried to make “an ugly film” conveying the
ugliness of death as a physical process, it may never have aired on PBS or been
funded at all. Dying carried a sizable $330,000 price tag (about $1.3 million
in 2013, adjusting for inflation) but was made under the auspices of WGBH and
the National Endowment for the Humanities. The very few deathbed docu-
mentaries shot exclusively on celluloid share this type of pedigreed patron-
age—most notably, well-established documentarian Frederick Wiseman’s Near

It is economically unsurprising, then, that a concentration of deathbed
documentary production in the United States did not appear until advances in
video and DV technology in the 1980s and 1990s combined with the cultural
forces discussed earlier. At that point, microbudget projects became possible—
usually arising out of the wish to document one specific person’s death rather
than beginning as an idea for a documentary that then found dying patients to
record (as Dying and Near Death began). Examples include Sick: The Life and
Death of Bob Flanagan, Supermasochist (1997, Kirby Dick) and Southern Com-
fort (2001, Kate Davis), in which filmmakers were drawn to the stories of two
fascinating individuals who were dying. The Andre Show (1998, Beverly Peters-
on) and Death: A Love Story (1999, Michelle LeBrun) were prompted by deaths
within filmmakers’ own families: of an adopted HIV-positive son and a hus-
band, respectively. And Silverlake Life features a filmmaker turning his camera
on his own slow dying. Davis emphasizes how crucial affordable video equip-
ment and tapes have been to this kind of documentary work: “Southern Comfort
is an example of finding a story and just going and taking a small camera and
doing it. I had no support when I started, no funders were interested. . . . But
with a DV camera, one can shoot a film for virtually nothing.

Though video’s capacity to shoot for long periods at a stretch is more essen-
tial to chapter 3’s central documentary, The Bridge, it also plays a role in death-
bed documentaries. The expanding duration of dying as a process recommends
a recording device that can be patient—able to sit and wait with the dying,
unsure of when important moments in this process will occur and how they
will signal themselves. An anecdote mentioned by David Kerekes and David
Slater in their study of cult films, Killing for Culture, helps illustrate this point.
Describing a documentary called On the Bridge (1992, Frank Perry) about the
director’s battle with cancer, they explain, “Perry talks of how he toyed with
the idea of filming his own death, pressing the trigger of the film camera when
he felt himself slipping away. This because the film magazine would only be 10 minutes duration.\textsuperscript{59}

In addition to (and in aid of) reducing costs, video reduces the necessity of having a crew of trained operators to create a death documentary. In each of his visits to Sally, Bill, and Bryant, Michael Roemer had to bring a three-person crew to handle the camera, sound, and lighting equipment.\textsuperscript{60} Video shooting allows for less intrusive, more intimate encounters at the deathbed in later productions. Peterson and LeBrun are able to be alone with just their dying loved ones and a camera, and easy-to-use \textit{dv} cameras make that possible for nonprofessionals, too, in Kirby Dick’s \textit{The End} (2004) and \textit{Time of Death}. Dick follows the final months of five hospice patients partly through professionally shot footage and partly through footage the dying and their families record on cameras he lends them; \textit{Time of Death} similarly lends out cameras to participants and mounts them on car dashboards, unstaffed, for capturing private conversations while subjects drive together. Also taking advantage of user-friendly cameras, \textit{Silverlake Life} and \textit{The Andre Show} include video diary segments shot by the dying themselves, alone with just the camera. Even a debilitated AIDS patient and a young child, in these films, have the minimal strength and knowledge, respectively, required to videotape themselves. Video cameras thus allow for the kinds of stories (over stages) Larry Churchill calls for: stories told directly by the dying.\textsuperscript{61}

With all the practical advantages video and \textit{dv} provide for death documentarians, there is one outcome of this technological transition that is more ambiguous: the changed aesthetic qualities of a video image, compared with a celluloid image. This contrast is starkly apparent in Wim Wenders and Nicholas Ray’s death documentary, \textit{Lightning over Water} (1980), which was shot on both 35mm film and Betacam videotape. As the image switches back and forth from film to video (a fairly early, low-definition type), the audience must readjust over and over to the soft, undersaturated video with its lines of interference or discoloration. Comparatively, the film stock looks crisp and rich. The contrast resonates with the dying Nicholas Ray’s declining health, his body a shriveling remainder of the strong form it used to hold.

The contrast within \textit{Lightning} is echoed in a comparison of \textit{Dying} to a later \textit{dv} film like \textit{The End}. The color 16mm image in \textit{Dying} is vibrant, sometimes even breathtaking, as when warm evening sunlight washes over Bryant and his family as they look for his parents’ graves in a southern cemetery. Its quality matches Roemer’s positive tone perfectly, emphasizing the vibrancy of Sally or Bryant even in the face of their deaths. \textit{The End}, by comparison, displays the dying with a marked flatness and colors that appear washed out—visual quali-
ties we associate with low-budget DV but also with the space of the hospital and its sterile, clinical feeling. Even in segments that strive for a positive tone, it is hard to overcome the mood created by our aesthetic confinement in drably presented deathbed interiors.\textsuperscript{62}

The Return of the Body, and of Spectacle, in \textit{Sick} and \textit{Silverlake Life}

Ontologically, theorists typically associate film with materiality and embodiment, video with immateriality and disembodiment. While these distinctions are technical and not intended to comment on the objects that film and video display on screens, it feels significant, nevertheless, that supposedly immaterial video would be the medium to expose the materiality of dying. That exposure happens most dramatically in the 1990s with \textit{Silverlake Life} (analog) and \textit{Sick} (digital), documentaries that function as a corrective to Roemer’s pioneering celluloid film \textit{Dying}, with its absence of bodily scrutiny. Video is the medium that accomplishes this task for two main reasons. First, as discussed earlier, it provided a means for doing low-budget documentary work on difficult subjects that might not attract institutional funding—like dying, especially when the grim decline of the body is a focus. Second, its rise as a viable tool of documentary production coincided with a period of increased discourse on dying bodies in the United States, due to the developing “revival of death” and especially to the massive memento mori the AIDS crisis represented for some Americans. \textit{Silverlake Life} and \textit{Sick} do restore the physicality of death to a place of prominence, but they retain the whole-person orientation of Kübler-Ross. Further, by focusing on dying people with nonnormative sexualities and idiosyncratic ways of coping with mortality, they exemplify the post-1960s exaltation of the individualized death—perhaps at the expense of contributing to a nova ars moriendi or reminding the audience of their own inevitable demises.

Kirby Dick’s documentary \textit{Sick} (1997), about his dying friend, is the more explicit of these two in its exposure of the dying body, even though the disease that afflicts Bob Flanagan is mostly invisible to the camera. Cystic fibrosis (\textit{cf}) is a genetic disease that continually fills the lungs with mucus, causing difficult breathing, coughing fits, and a severely truncated life span. It leaves no external marks, like the visible lesions that \textit{hiv} would dot across the bodies of \textit{Silverlake Life}’s subjects—an invisibility that frustrates Bob, who has to cope constantly with the hidden physicality of his illness. In response, he customizes a “visible man” model (clear, plastic miniatures used to show the normative work of internal organs) to reveal the way his own body works, mixing concoctions
to represent mucus, feces, and semen and rigging the model to dribble these out of its respective orifices. Parallel to Bob’s individualized visible man model, *Sick* is structured around a creative strategy of visualizing its dying subject’s internal pain, circuitously representing it through the external pain of Bob’s s/m sexual practices. With a *c/f* death sentence hanging over him since childhood, Bob learned to cope with the pain he could not control through pain he could master as a sexual submissive—a sort of makeshift, eccentric palliative care. Together with his dom partner, Sheree, Bob turns this interaction between *c/f* and *s/m* into installation and performance art, displaying his consensually battered body for audiences at both s/m clubs and high art galleries, and for Dick’s documentary camera.

Bob’s end is foreshadowed after his forty-second birthday and a big solo gallery show in New York, when Sheree shoots a video of him in which he is depressed and refusing a birthday spanking. In another intimate, late-night video from some months later, an upset Bob asserts to Sheree that he is now feeling too sick to submit to her—sexually or even mentally. Soon Bob checks himself back in to the hospital for what turns out to be the last time. Dick and his camera follow, in accordance with Bob’s condition of participation in this documentary: that Dick would have to continue the project through Bob’s death. The progression toward that “moment,” though, is unpredictable, as we see Sheree and nurses tending to Bob in a coma, and then a later time when he has regained consciousness. He tells Sheree he loves her and then wonders aloud, “Am I dying? . . . What is going on? This is the weirdest damn thing . . . the stupidest . . . I don’t understand it.” A subsequent scene of Sheree comforting a spastically breathing but otherwise unresponsive Bob seems to be leading into impending “moment of death” footage, but the image cuts out as we hear the click of a manual slide projector.

Instead, *Sick* returns to the previous century’s popular form of the postmortem photograph with a montage of images Sheree took of Bob’s corpse in the hospital, accompanied by the slide projector sounds. We see his body lying in the hospital bed—eyes closed, mouth open—as medical staff check him with a stethoscope. They move him onto a gurney, and his naked body is taken to a new hospital location where Sheree photographs close-ups of his face, chest, and genitals (arranging his hands to touch them). The recourse to still images once Bob’s body has stilled concludes the film’s saga of embodiment rather poetically. Further, the close-ups of his tattooed and pierced genitals and “S” scar (where Sheree once carved her initial into his chest) reassert Bob’s individualism. Even as a corpse, absent of personhood and lying in a sterile environment, Bob—the film asserts—carries his uniqueness beyond the boundary of death.
Blending a slow process of dying from disease with the prolonged and pleasurable pains of s/m—and doing so in public, through sexually explicit art—certainly qualifies as the unique, post-1960s “death of one’s own.” By playing Bob’s sexual pain and cf pain off each other in Sick, Kirby Dick solves the central aesthetic problem of the deathbed documentary, reinvigorating it with the visual spectacle of painful bodily destruction that violent death provides and natural death does not. We do not see bullets piercing flesh or fatal wounds bleeding, as the works in chapter 1 feature, but rather needles piercing Bob’s penis, weights suspended from his genitals, letters carved into his chest, objects pushed into his anus, and so on.

Although “moment of death” footage is once again absent, Dick offers two substitutes for this missing piece of Bob’s story. The first is a discussion of Bob’s Wall of Pain art piece. Sheree and Bob had set up a camera with which he took a picture of his own face at each instant that she struck him with a paddle, flogger, whip, crop, and so forth. The resulting large photo collage that displays all these faces shows the same concern for temporal exactness as chapter 1’s photographs that pursue the “moment” of violent death, providing a substitute locus of moment-ness in relation to the body within Sick. The second substitute is a scene that begins, without an establishing shot, on an extreme close-up of Bob’s penis resting on a wooden board. Bob’s hands quickly enter the claustrophobic frame holding a nail, which he drives into the head of his penis with a hammer, anchoring it to the board. Shortly, he pries the nail out with the hammer, and Sick cuts to an elaborate low-angle shot through which Bob’s profusely bleeding penis drips blood onto a clear barrier above the camera. A song called “Hammer of Love” strives to maintain Bob’s irreverent, gallows-humor spirit during this challenging scene. The violent penetration of Bob’s penis marks the peak of his endurance, the most squirm-inducing performance of suffering the film can display. Thus, while the expected climax of the death story in Sick (Bob’s “moment of death”) is omitted, I argue that a spectacular climax for his sex story is showcased in its place—not temporally in the film’s timeline but structurally in its visual and emotional progression.

Silverlake Life, though it does engage in pointed forms of bodily display, does not strive for these heights of spectacle, focusing more on the quieter moments of the dying process—on making newly public its private daily texture. As noted previously, Silverlake Life chronicles the life and illness of HIV-positive partners Tom Joslin and Mark Massi. Finding a purpose in the time he has left, Tom becomes determined to make this documentary—carried on after his death in 1990 by Mark (who dies in 1991) and by Tom’s former student, codirector Peter Friedman. Where Roemer asserted that his dying subjects “di-
rected the film and gave it its direction,” that dynamic is literal in *Silverlake Life* with its dying director. Tom and Mark shoot most of the footage themselves, capturing intimate moments at home, trips to doctors’ offices and alternative therapies, arduous errands, two vacations, and visits from friends and family. The variety of events and moods that *Silverlake Life* covers emphasizes the duration of Tom’s dying, as do the film’s lapses in linearity. Peggy Phelan describes its distinctive temporality as follows: “Dying is not in the future; death is not in the past. Dying is. And this is a film that shows us how long that ‘is’ is, how many shapes and colors and emotions live and die in it.”

At many points in the film, Tom, Mark, or their doctors examine their deteriorating bodies, and the camera does, too, offering clear shots of Mark’s back covered with Kaposi’s sarcoma lesions or the lesion that grows over Tom’s eyelid, sealing it shut. Eventually, Tom’s health worsens to the point that he begins receiving hospice care at home—a moment he denotes as starting a grim countdown to death, based on what he says is the average survival time after the start of hospice care (two months). Mark continues recording footage, and for a while Tom is able to keep up his diary-cam entries. Then after we have seen Tom lose all his energy and most of his ability to speak, *Silverlake* cuts abruptly to a shot of his corpse lying in their bed, with Mark informing us that he just died. The documentary lingers with Mark for a while, recording Tom’s funeral and some of Mark’s grieving. When he receives Tom’s ashes (taping the experience with a tripod-mounted camera), the body asserts its materiality one more time: Mark cuts himself while opening the delivery box and then must handle and contain the ashes that spill from a punctured bag.

A sense of political urgency suffuses *Silverlake Life*—a passionate desire to showcase the love between Tom and Mark and the lesions that ravage their bodies and signify their coming separation. That urgency emerges from this particular death’s integration into the larger casualty list of the AIDS crisis, whose sufferers struggled for support and visibility—but also sought to determine what kinds of visibility would be helpful or harmful to their cause. Activists, artists, and the mainstream media all especially struggled with how to visually represent bodies—like Tom’s and Mark’s—infected by the disease. Initially, it seemed crucial to display these bodies and raise awareness about AIDS and its physical devastation—a task the mainstream media often avoided. Photojournalist Don McCullin explains part of this resistance: “In terms of photojournalism, the AIDS issue has an enormous problem. It has to appear in print. Yet it’s so visually unkind to the eye. It infringes upon the comforts of magazines themselves because it’s difficult for the business side to run advertising up against.” As the AIDS crisis progressed and its bodies gained visibility,
some activists saw a shift in problems of representation, from the invisibility to the exploitation of dying bodies, put on display with little attention paid to the individuals inhabiting them. Protesters outside a 1988 MOMA show of AIDS photography, for example, expressed this frustration through flyers reading, “No More Pictures without Context” and “Stop Looking at Us; Start Listening to Us.” Part of Silverlake Life’s success, as a film and as a piece of activism, stems from its lesions and love approach, from its union of two distinct representational needs during the AIDS crisis: bodies to look at and individuals to listen to. The documentary made public politically volatile sights that had been private, and it did so on two levels: it unfolded on camera the process of an actual natural death (of a highly political type), and it openly displayed love and physical affection between gay men during an era of virulent homophobia.

In the 1980s, the AIDS crisis interrupted the simplified narrative of death in the twentieth century where lives end later, less frequently, and out of public view. The disease brought a return, for some, to the culture of the nineteenth-century epidemic: people were infecting each other and dying on a massive scale. The U.S. public perceived that death was mostly befalling gay men, and while that group was not fully integrated into or accepted by mainstream culture, it was vocal and creative, making its plight known through activism and art. In addition, AIDS challenged the narrative of twentieth-century death by refuting the idea that traditional support systems for the dying had disappeared. As Walter generalizes, dying becomes unmoored in the twentieth century because “community and religion, the two underlying supports of habitual ways of dying and grieving, are in long-term decline.” Yet for men like Tom and Mark dying of AIDS, the queer community and the active networks of support it provided were essential. This discrepancy again reveals the bias toward hetero, white, middle-class dying in much scholarship on the subject, which does not seem to count thriving sexual and ethnic communities when assessing the decline of community in the twentieth-century United States. Multi-pronged strategies for getting the public’s attention and sympathy during the crisis emerged from that queer community: activists exposed the scale of the problem through projects like the AIDS quilt, but they also sought to humanize individual victims. This latter approach demanded death stories, and especially highly individualized, autobiographical death stories like Silverlake Life that would distinguish one dying gay man from all the others, making one death “in full detail” matter where abstract thousands might fail to make an impact.

Such a project would have seemed more possible in the early 1990s than a few decades prior because documentary began to yield significant autobiographical work only in the 1970s—at roughly the same time that U.S. death
culture began to valorize the individualized death as the good death. Both death culture and documentary in this era were reacting against the sterile, scientific discourses that dominated them: body-focused hospital dying and the objectivity-obsessed direct cinema movement, respectively. Fueled by the influence of American avant-garde filmmaking, second-wave feminism’s principle that “the personal is political,” and a general inward turn in 1970s American culture, documentarians began to point their cameras at themselves. Joslin himself was part of this trend early on with a documentary about his coming-out process, *Black Star: Autobiography of a Close Friend* (1977), clips of which are shown in *Silverlake Life*. In between his production of *Black Star* and the posthumous release of *Silverlake Life*, an abundance of intriguing autobiographical documentaries had appeared, from filmmakers such as Michelle Citron, Ross McElwee, Su Friedrich, Marlon Riggs, and Sadie Benning. And *Lightning over Water* had pioneered the combination of real death and (partly) autobiographical filmmaking.

By using the machine that has most defined his life, the camera, as a tool in his dying, Tom revives the deathbed customs of previous centuries, in revised forms. Both Ariès and Kübler-Ross trace histories in which the crowd that used to gather at the deathbed suddenly dissipates in the early twentieth century, leaving the dying increasingly alone. They see this dissipation as a problem for two reasons: it deprives the dying of companionship and support, and it prevents the living from witnessing death. With his camera, Tom repopulates his deathbed with virtual witnesses. This act clearly helps alleviate the second part of the preceding problem by exposing audiences to a condensed and mediated version of a dying process. Though these witnesses are temporally and spatially separated from Tom’s actual deathbed, the thought of their eventual presence—elsewhere and elsewhen—seems to give Tom strength as he dies, the sense of purpose emphasized in post-1960s death culture that can soothe the pain of endings.

Tom and the other filmmakers who document death also reconnect the process of dying with a nineteenth-century process of grieving: the meticulous production of artworks and craftworks to aid in mourning. These included lockets and frames to hold photographs, as well as elaborate patterns woven from the hair of the dead. Mostly made by women, the primary guardians of memory in that era, such works lingered over the bodies of the departed (directly, through hair, or symbolically through photographs) to cope with their loss. Of these activities, Geoffrey Batchen writes, “No doubt the time spent in crafting such things was part of the period of mourning, a time of contemplation and creative activity that helped to heal the bereft as well as memorialize
Work to make these mementos contributed to a gradual process of working through. Those customs and their functions are revived and revised in films like Silverlake Life, Death: A Love Story, and The Andre Show as loved ones process a death by documenting it—aided by the demanding work of shooting, editing, and distributing. Batchen points out that the duration of labor these crafts required supported the grief function, too: “The labor of embroidery ensures that the act of remembrance would be painstaking, extended through time, deliberated.” The process of filmmaking, like the process of dying, is long and multifaceted, allowing this channeling of grief to unfold and evolve over time. In the case of Silverlake Life, the healing labor is shared by the dying, put to use by Tom in coping with his own death and by Mark and Peter in grieving for it.

That this labor is done on video rather than film is again significant, and not just in terms of production costs—though the boxes of cassettes that Peter Friedman assesses with his camera, containing Tom’s forty hours of footage, make clear the project’s economic unfeasibility on celluloid for a filmmaker of limited means. Shot in the late 1980s and 1990 and then released in 1993, Silverlake Life is the first deathbed documentary of the home video era, when the American public had affordable access to home video cameras for their own shooting and VCRs for home viewing. Made mostly in the home for an audience who might view it at home (as some did on PBS even before its VHS or DVD releases), Silverlake Life exudes the intimacy of home video combined with a professional filmmaker’s aesthetic sense and structural intentions. One of the powers of the video camera Tom and Mark exploit is its mobility. With it, a very ill man can still function as a full crew, shooting image and sound with a single, affordable machine, as we see in Silverlake Life’s first-person camera sequences. Tom, for example, shoots what he sees as he walks into a store to complete an errand—capturing the exterior, the aisles, and his frustrating effort to pry one plastic tub from a stiff stack of them. The audience’s oppressive and disorienting confinement to point-of-view shots in this sequence underscores the pain of confinement in a dying body—another strategy Silverlake Life employs for helping its audience access the internal, invisible experiences of dying. The location of the body is emphasized as a confusing and unpleasant place, for the audience in terms of spatial disorientation and for Tom in terms of suffering and progressive debilitation.

Elsewhere, it is the immediacy of video rather than its mobility that becomes important. Some of the footage used in Silverlake Life is shot off of a television monitor rather than just edited into the film. That extra level of mediation indicates a deliberate emphasis on the act of viewing, on the everyday
primacy of spectatorship. And because video is the medium, image creation and image spectatorship can happen simultaneously. This point is made when Tom and Mark set up a camera, point it at themselves lying in bed, and run it directly through a monitor. We see them looking offscreen at the very same image of themselves that we are seeing, but they are watching it as they create it. The content of the clip is mundane, with the two of them talking about filming themselves, arranging the composition, examining marks their disease has made on their faces, and making funny hand motions to simulate trees. The fact that the content is so understated stresses that the real importance of this clip is not what we see but how we are seeing it, how it is constructed, and the comment it makes on the role of media in our lives. We are seeing the moving image directly realize its dual function as window and mirror, with the instantaneousity of video providing for the latter possibility. Michael Renov perceptively makes this point: “Durable, lightweight, mobile, producing instantaneous results, the video apparatus supplies a dual capability. . . . it is both screen and mirror, providing the technological grounds for the surveillance of the palpable world, as well as a reflective surface on which to register the self.”

Silverlake Life carries this dual function through on a large scale, as discussed earlier, providing an informative window on death for the living and a therapeutic mirror of death for the dying individual.

Here, media and life are intertwined, as video is a tool that both records life and shapes it. As we have seen, both aspects are essential to the camera’s role in Tom’s death, where it both documents and helps him cope with his dying, molding it into a meaningful and individualized process. The interplay between creation and spectatorship in Silverlake Life challenges typical power dynamics between moving image producers and consumers. In the early years of an age when nonprofessionals could increasingly cross that line from consumer to producer using video technology, Silverlake Life models how to do so—and why to do so. Media producers in Hollywood told Mark that he could close the eyes on a corpse and they would stay shut, as discussed earlier. But Mark has the power to make media, too, and he can use it to announce that Hollywood is lying—about this aspect of death and so many others.

The extent to which Silverlake Life could only have existed in its current form on video is demonstrated in the shots of most immediate proximity to the absent “moment of death.” The film cuts from Tom in a severely depleted state on his deathbed to Tom’s corpse—still lying in bed but with his glasses removed, a sign of an end to his spectatorship and subjectivity. Here, the audience bears witness to an outpouring of grief from Mark, who has been attending to Tom and is also running the camera. Mark records but also speaks, in
a quavering voice interrupted by sobs: “[Moan] This is the first of July, and Tommy’s just died. [Inaudible] when he died, and I sang to him. I sang to him, [singing] ‘You are my sunshine, my only sunshine, you make me happy when skies are gray. You’ll never know dear how much I love you, please don’t take my sunshine away.’ Isn’t he beautiful? He’s so beautiful. I love you, Tommy. All of us—all of your friends will finish the tape for you, okay? We promise. We promise. Bye! Bye, Tom!”

This scene, full of raw emotion that both draws us in and shakes our resolve to keep watching, illustrates a tension between the dual role people play as documentarians and mourners in such intimate documentaries of natural death. Despite the irrepressible emotion in his voice, Mark begins with a faint attempt at objective reporting. He gives us the facts—“This is the first of July, and Tommy’s just died”—but uses a fond nickname for his subject/partner. Mark maintains a third-person report of events for a short while, but after reenacting the way he sang to Tom, he slips back into direct address, speaking directly to the corpse’s object as if it were still the beloved subject. The handheld camera—which Mark has operated elsewhere in the film with professional steadiness—shakes uncontrollably, seeming to respond to the tragic stillness of Tom’s body with compensatory, frenetic motion. The cause, of course, is Mark’s sobbing, as Silverlake Life fulfills Sobchack’s call for documentary to register its response to death visibly, to offer “signs of the filmmaker’s situation and stance” through cinematography.75

Silverlake Life builds grief into its very bones, manifesting it not just in what we see but also in how we see it through Mark’s fragile point of view. In this scene, the one-man camera crew is himself openly grieving for the subject of his documentary that is also the object of his affection—emoting in a way that a film crew’s presence would likely inhibit, and recording in a way a filmmaker from outside the circle of loved ones (like Roemer) never could. The scene also marks an immediate transference of subjectivity within Silverlake from the dying person to the closest mourner, once that person becomes a corpse. Sick employs the same strategy, when Bob’s dying moments are immediately followed by Sheree’s intimate photographs of his dead body. This shift of perspective within deathbed documentaries deviates sharply from the conventions of violent death documentary footage—Abraham Zapruder’s in Dallas, for example, or Vo Suu’s in Saigon—where the perspective of the cameraperson is almost always generic.

Despite the tension between Mark-as-documentarian and Mark-as-partner, Silverlake Life itself and the act of documenting at this moment interject a promise for the future into this scene of parting with the past. Mark promises Tom
2.3. Tom before his death (Silverlake Life, 1993, Tom Joslin and Peter Friedman, New Video Group).
2.4. Tom right after his death (Silverlake Life, 1993, Tom Joslin and Peter Friedman, New Video Group).
that he and Tom’s friends will “finish the tape for you,” fulfilling the meaning-making function the camera brings to Tom’s death. The camera helped define the filmmaker Tom’s life and then helped him forge a unique, individualized death. Both his life and his death will now be preserved—for a time, at least—on video.

*Silverlake Life* thematizes the act of preservation it is performing through two moments that begin and end the work. The first comes in the opening moments, situated after Tom’s death, just before Mark’s comments about trying to close Tom’s eye. Mark naps on his couch, and the camera pans right, revealing a monitor on which a videotape from Tom plays. The screen shows what we later learn is the first footage Tom shot for *Silverlake Life*: a close-up of himself with a medium-specific electronic matte laid over it, framing his face in a heart shape with the words “Mark, I love you” written alongside it. Thus, even within *Silverlake Life*, we see footage shot for the project already serving one of its main functions: preserving a trace of Tom to comfort Mark and others after he dies. This function is performed even more poignantly in the final scene, when Tom has (again) died and Mark has just been interviewed about sensing his presence in the apartment. The film closes with a musical number from *Black Star* in which Tom and Mark—younger by more than ten years—do a lightly choreographed dance to the doo-wop song “I Met Him on a Sunday,” ending arm in arm looking at the camera. This scratched and dated celluloid, displayed through a full-length video feature, enacts a restoration to health and life for Tom and Mark—both dead at the time of *Silverlake Life*’s release.

These two scenes in which moving images resurrect the dead in *Silverlake Life* reveal the most important way in which video aligns with, rather than diverges from, its technological predecessor, film: it preserves. Video, too, derives from the “mummy complex” that Bazin saw in the roots of the plastic arts. For most who have experienced loss, it matters little how a moving image returns their dear departed—through an indexical process or not, if they are even aware of that difference. It matters only that a camera has “secure[d] the shadow,” allowing a partial return across the border between death and life.77

**Conclusion: Individualism Guards against Identification**

In *Sick* and *Silverlake Life*, we see the cultural pendulum recenter—back from the one extreme of body-fixated hospital dying in the mid-twentieth century and the other extreme of overwhelmingly psychological discourse about dying in the post–Kübler-Ross 1970s (including *Dying*). Exploring both physical and emotional aspects of natural death in a documentary mode, these films also ex-
emplify the revised good death, the “death of one’s own.” Highly individualized stories about dying, they focus on men outside the sexual mainstream finding novel ways to cope—through documentary production or the controlled pain of S/M—with dying slowly at a relatively young age. A notable portion of the small subgenre of American deathbed documentaries share this penchant for eccentric end-of-life stories: *Lightning over Water*, with its celebrity death of director Nicholas Ray; *The Andre Show*, in which the dying party is a young HIV-positive boy who has been adopted by a filmmaker; and *Southern Comfort*, which features a trans man dying of ovarian cancer in rural Georgia.

But in aligning so well with the neoliberal individualization of the new good death, these films sacrifice much of their *memento mori* potential. The *memento mori* cautions, “remember you will die,” but neither Bob Flanagan nor Tom Joslin dies a widely relatable death. “You” may not feel implicated by seeing two men in their forties waste away from CF and AIDS—diseases that are genetic (and detectable from childhood) or preventable (because many rationalize that they will not catch those). This disassociation appears in the audience responses to *Silverlake Life* that PBS received after the broadcast. From these, it seems that the film prompted viewers to identify with the experience of witnessing a loved one’s death rather than imagining their own deaths: the dying Tom reminded some viewers of their own deceased relatives and of the process of watching them die.

Lack of direct identification with the dying also crops up around the edges of *Sick*. Its DVD includes a documentary short, *Sarah’s Sick Too*, which profiles a young fan of Bob’s with CF. Her visit with him is documented in *Sick*, and the subsequent short updates viewers on her life since the film’s release. Born of the disease they share, Sarah’s identification with Bob is apparent in both the film and the short, especially when she tapes herself rewatching Bob’s death scene from *Sick* at home on VHS. Turning away in tears before it ends, she remarks, “It’s really hard to go through life knowing how you’re going to die. It’s even harder to see it.” Her own painful ability to translate this past death preserved on video into her own future death is opposed by the implicit inability that she describes of other viewers to do the same: “Most of the people who have seen this film that I’ve talked to say that the hardest thing to watch was when Bob nails the head of his dick to a board. And everybody who says that, I always ask them if they really watched the whole movie and did they see the ending. Because I would think that the hardest thing to watch would be him dying.” While the highly visible spectacle of genital impalement connects with viewers painfully, the internal and emotional pain of Bob’s death does not make their own flesh twinge to the same degree.
As a number of psychological studies have shown, Americans asked to imagine others’ deaths and their own deaths offer more realistic descriptions of the former and more idealized descriptions of the latter. This blind spot about one’s own death affects even medical professionals who have regular contact with the dying.79 Viewers of Sick, Silverlake Life, and the other documentaries about unique natural deaths may thus mourn their subjects at a comfortable distance, sympathizing without identifying. A refusal to frame dying as a generalizable experience is both the strength and the liability of these documentaries in their usefulness to documentary’s efforts to make death visible.

In her brief consideration of deathbed documentaries in “Inscribing Ethical Space,” Sobchack describes them as “unblinkingly record[ing] the subject’s death.”80 As demonstrated earlier, however, the camera’s eye does blink in these sagas, and always at the same point. Its blink effaces the “moment of death” in Dying, Sick, and Silverlake Life and in every U.S. deathbed documentary I have studied, keeping the focus on the process of dying and avoiding the false sense of climax that such a moment could present. The “moment of death,” however, is not just absent because it might steal the show or even because it is so difficult to identify and isolate. It is absent because that recorded sight’s “full detail” would likely deflate the idea of death as heroically individualized. Roemer’s idealistic belief that “people die in the way they have lived [and] death becomes the expression of everything you are” cracks and breaks apart if brought too close to the biological end of life—the phase in which hospice professionals refer to a patient as, finally, “actively dying.” By that time—in an age of modern medicine, with its strong painkillers and sedations—the last vestiges of unique personhood have usually evaporated from the dying body. For the duration of “active dying,” the dying party sinks into a state reminiscent of Giorgio Agamben’s “bare life”: the state of being merely biologically alive, unable to participate in sociopolitical life.81 While the longer process of dying could possibly evoke “the expression of everything you are,” its conclusion in death tends to be an act of bare mechanics—shifting patients from alive to dead in a routine sequence that presents precious few opportunities for individualism. This homogeneity becomes particularly apparent in Time of Death, as this episodic documentary television series shows new, unique patients taking their own paths through the dying process but ultimately reaching the same state of hardly living, lost subjectivity week after week.

This darker reason for the “moment of death’s” absence becomes apparent in the Canadian documentary Dying at Grace (2003, Allan King), which provides a useful counterpoint to the U.S. films discussed earlier. Grace uses a
strictly observational, direct cinema style that keeps the audience at a greater emotional distance from the dying than the interview-laden and frequently autobiographical American films. King tracks the dying processes of five patients at the Toronto Grace Health Centre’s palliative care unit. One seems to draw the camera in a bit more than the others, and her death provides the climactic final scene of the film. Eda Simac has remained warm, upbeat, and even helpful to the other patients in the unit through her long battle with breast cancer. She seems, in most ways, to be dying a model good death of the post-1960s era: doing palliative care rather than accepting painful life-prolonging treatments and maintaining her unique and lovely personality through this difficult experience. Had Roemer been making this documentary, he may have stopped filming around this point, as Dying showed very little footage beyond a certain stage of debilitation. But King presses on with Eda, and her ability to forge a death that is an “expression of everything [she is]” falters as the pain and medications to suppress it overwhelm her. Her resilient smile disappears as she enters a frightening state of moaning distress, then later simple unconsciousness. Not a personal failing, Eda’s loss of self is a consequence of modern dying and, ironically, especially of hospice and palliative care, whose mission to provide comfort and suppress pain requires medications that inhibit alertness and eventually consciousness. Interesting moments in Grace reveal this tension, as nurses try to persuade suffering patients to take more pain medications and some patients resist because they fear that they will no longer feel like themselves. Like all of the five patients featured in Grace, Eda’s individual personality falls away as she becomes just a (well-cared-for) barely living body in a bed.

The final shot of this two-and-a-half-hour journey delivers what Grace has not shown up to this point and what no U.S. deathbed documentary shows: an attempt to pinpoint and display the “moment of death.” Eda appears in close-up, unconscious, with her eyes half open and mouth gaping, her breaths coming as intermittent spasms—until they stop coming. The sheer rarity of this taboo documentary sight on-screen and its placement at the very end of a long and emotionally demanding film give it a certain power, but in other ways this climax does not feel climactic. Eda’s body looks almost exactly the same as those of the other four patients King has shown approach the very end. She exhibits what have, by this point in the film, become rote conventions of the last phase of dying: lying in a bed, unconscious, eyes open but staring blankly, mouth gaping, breathing raggedly. In the accumulation of these scenes, one conclusion is unavoidable: an individualized “death of one’s own” must be crafted long before the process of dying comes to an end. Natural death’s final phase today
2.5. Eda takes her last breaths as the camera records (Dying at Grace, 2003, Allan King, Criterion Collection).
is, so often, hopelessly routine—an experience of sparse biology common to all those who used to be individuals, and one that would not fit comfortably in documentary stories about individualized good deaths.

Chapter 1’s conclusion referenced filmmaker Harun Farocki’s troubled reaction to documentary images of violent death—napalm deaths during the Vietnam War, whose brutality and injustice seemed to foreclose any possibility of an “appropriate” response. Farocki chose a gesture of self-injury, burning his arm with a cigarette to endure what he acknowledged to be a hopelessly partial version of the effects of napalm on human bodies. In the face of natural death, less frequently characterized as “unjust,” the stakes and requirements of our roles as viewers change. The documentary representation of these deaths generally does not solicit an active response, does not function as a call to arms. As we watch these processes of dying, a simpler reaction than Farocki’s seems adequate—one that can be wiped away without leaving a scar. We cry. In this way, the tiny subgenre of the deathbed documentary is kindred to Linda Williams’s “body genres,” which encourage a physical connection between the bodies on-screen and in the audience through mimicry. Here, we are meant to mimic not the dying but the living who mourn them, perhaps shedding tears alongside Mark in Silverlake Life. The act is a cathartic release, one that lets us keep a safe distance from the more difficult revelation implicit in the bodies dying on-screen: that in time we will mimic them, too. As Sally remarks in Dying, “All you have to do is wait.”