
Caring at the End of Life was filmed for the purpose of demonstrating the multifaceted actualities of end-of-life care in the acute care setting. It offers no simple, definitive procedures for making decisions about the end of life. Some initial scenes in the video are in black and white. This is effectively suggestive of most health
care providers’ desire for the topic to be black and white or less ambiguous than the complex reality of end-of-life decision making. The four-part video illustrates cases from the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT)—and the director allows the viewer to hear perspectives of patients, family members, nurses, and physicians.

Part 1. Living with dying: The realities of hospitalization. In this segment, patients and family members talk about their health care experiences as the end of life draws near. The symptoms of pain and shortness of breath are profoundly distressing to both the patient and family. Effective pain management is often challenging. In addition, patients must deal concurrently with the setbacks associated with rapidly progressing disease, complications, and comorbidities. Other frustrations surrounding end-of-life care include difficulties communicating with health care providers, lack of knowledge regarding medical treatment decisions, unpredictability of the course of illness, and helplessness in watching a loved one suffer.

Part 2. Making decisions: Deciding when to use life-sustaining treatment. Here the viewer learns about Stanley, a young adult with anoxic brain injury. Stanley does not have an advance directive and the health care providers express their moral distress about not knowing what Stanley wants. They urge his family members to forego treatment because they see that patient suffering seems to outweigh the chance for sustaining life with a life of quality. Caring for someone, such as Stanley, is also agonizing to health care providers.

The narrator of the video defines advance directives; then a physician and a few nurses discuss the strengths and weaknesses of the documents. Some patients and family members clearly state their wishes for all treatment, yet others wish to have limited or no life-sustaining treatment. Regardless of patient and family treatment preferences, clarification of treatment wishes by nurses with patients is difficult, emotionally laden, and time consuming.

Part 3. Making decisions: Deciding when to withdraw life-sustaining treatment. In Part 3, the viewer witnesses opposing views of a patient’s family member and the health care providers. An intern talks to Stanley’s father about the health care team’s desire to limit treatment based on Stanley’s prognosis and apparent suffering. Stanley’s father explains to the intern and nurse several reasons for wanting to continue life-sustaining treatment—reasons based on his faith and knowing that Stanley is one who fights to live. Several nurses and a physician discuss the difficulties involved in making decisions to withdraw life-sustaining treatment.

Part 4. Living with dying: Acknowledging medical fallibility. In the final segment, Stanley surprised health care providers when he revived from the coma and was able to communicate that he wanted to continue treatment. He was discharged from the hospital and spent several months at home with his family.

The central message conveyed to health care providers by this video about caring at the end of life is that health care providers are charged with helping patients live with dying. They may do this by decreasing suffering and attempting to match medical treatments with patients’ and family members’ values. Another over-riding theme in Caring at the End of Life is that a sincere, caring, gentle approach by health care providers with patients and families at the end of life can be most helpful with a complex decision process heavily influenced by individuality, culture, and personal beliefs.

Two compelling factors make this video powerful. First, the sincerity demonstrated by health care providers by tone of voice, facial expressions, posture, unrushed demeanor, and the use of touch, all conveyed caring and trust while discussing with patients and families a very difficult and personal topic. Second, the patients are real; there are no actors. Their suffering is clearly evident by the concerned looks on their faces, shortness of breath, or tears of anguish.

Students in medicine, nursing, social work, law, and pastoral care who view Caring at the End of Life will have an opportunity to better understand the magnitude and complexities of end-of-life experiences, as well as appreciate the need to approach patients and families with sensitivity and compassion. Caring at the End of Life could be beneficial to multidisciplinary members of hospital-based palliative care services to stimulate discussion or to emulate approaches to patients and families. Finally, the video has merit as an educational tool for other direct care providers who touch the lives of patients and their families at the end of life.

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