Andrew Crocker-Harris, Finney's character, does not electrify his students with something akin to an exciting chemistry experiment, as does the young science teacher, Frank. No, Andrew reads to them from the classics, developing with his voice the emotion lying within the words. Using ill health as an excuse to discharge him, the administration has refused to give Andrew a pension. Replaced by a younger man who will teach modern languages, Andrew also suffers the peevishness of his unfaithful wife, Laura, who has chosen the young, popular science teacher for her infidelity jaunts.

Surrounded by deception, the only one he can trust is a young student, Kaplow. Although chastised by his teacher in front of his classmates, Kaplow recognizes the real character behind the stoical mask worn by Andrew. And yet, Andrew's faith is dashed by his wife's bitterness when she attempts to lessen the importance of the young boy's gift to his teacher, a Robert Browning translation of Agamemnon. It is at this point that the younger science teacher with whom Laura is having an affair, realizes Laura's rancor and the tragedy of Andrew's life.

Andrew represents traditional values, and the past is an integral component of this prestigious English boys school. Large portraits and other historical trappings dwarf the newly-arrived language teacher as he is taken to the customary morning assembly. Throughout the video the camera focuses on the symbolic references to the traditional: the academic gowns, the cloistered buildings, the stark rooms, and the polished paneling. These are merely visual representations of times gone by. Andrew, too, is considered a relic who offhandedly suggests that, when he leaves, some of his present work eventually will be accomplished by a computer. One feels the influence of the up-to-date outside world creeping into the very soul of the school.

Frank, the science teacher, lives in the nearby village away from the school. He is truly an outsider, an American trying to be more English than the English, as Laura tells him when she steals away to his flat, only to be snubbed by him. Frank symbolizes the youthful doer of things, the popular personality who flaunts the normal moral codes, until he sees the effect of Laura's behavior on Andrew. Very emotional scenes involving Andrew take place during a cricket game. The clamor of the game envelops these scenes, functioning as a metaphor for that world beyond the hallowed halls. During the match, Andrew receives the gift, the Browning version of Agamemnon, and reacts emotionally to the inscription written by the young boy. As the game progresses, Andrew relates the story of the gift to his colleagues and his wife. Similarly, as Clytemnestra in the Greek tragedy butchered her husband Agamemnon, so too Laura brutally slays her husband, not with an axe but with stinging words.

Andrew agrees to speak first at the closing graduation ceremonies so that the departing cricketer and beloved teacher can present the meaningful final address. The administration wants a grand finale to the school term: a teacher can present the meaningful final address. The Way We Die: Listening to the Terminally Ill, 1/2 videocassette/25 min/color/1995. Producer, Jonathan Mednick. Distributor, Fanlight Productions, 47 Halifax St., Boston, MA 02130. 800/937-4113. Sale $195, rent $50.

The video opens with statements about the difficulties that have arisen due to technology advancements. The meaning of the death experience has become lost in the focus on technology and physical symptoms.

Scenario 1 portrays an old couple living at home. The gentleman talks about his feelings of being a burden to his vibrant 77-year-old wife and family. He recalls her asking, in anger, why he doesn't die. In times of stress he questions why he continues living and feels his family would be better off without him.

Scenario 2 portrays a young man who is being cared for by his parents when, as he puts it, they should be enjoying their golden years. They talk about quality of life as being a day-to-day decision and when quality, by his definition, is no longer present, they will stop fighting.

Scenario 3 concerns a recollection by a physician. A 12-year-old girl in the hospital ward for 6 weeks begged to return to that room from the intensive care unit where she had been moved to be in strict isolation. Her requests to go back to her room were finally taken seriously, and her physician and parents knew that this meant the end of her life. She was so happy to return 'home,' where cards from friends and mementos of her identity were all around. The physician told her parents that she was likely to die that night. During the night she had a crisis and the staff moved her back into the ICU. Her parents asked the staff not to move her, but their request was not honored, and she died in the ICU without her parents at her side. The physician uses this situation to illustrate how staff robbed the parents of their child's death to meet their own need to do what they thought was right.

In scenario 4 we see Jesse, an older gentleman with a tracheostomy requiring total care from his wife at home. She admits to feeling resentment at spending their retirement years this way. He is bleeding, and the physician talks with them about Jesse not being able to tolerate the procedures needed to discover the origin of the bleeding or the treatment. What do they think should be done? The wife greeted with a standing ovation. He has finally touched them.

This video reflects an image of the throw-away society grounded in the economics of big business. The old is replaced by the new, often without thought for the usefulness remaining. Andrew maintained a passion for the classics. He cared for his students, but he was not flamboyant about his concern. Andrew tried the best that he could under tremendous stress. The video is a tribute to the human spirit and its resiliency.

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The Gerontologist
agrees, and becomes tearful when admitting he does not think a transfusion is in order, but Jesse is not so quick to care if he lives or dies without the transfusion. The physician tells Jesse to think about it and states that they will not do anything he does not want. The physician talks about the difficulty and pain of taking care of a dying patient.

This video could be expanded or contracted to fit many educational situations. It is put together so that a presenter can select only one of the scenarios to make a particular point or pause for discussion after each scenario for a more in-depth educational interaction.

The video talks about the need to investigate what is meant by “everything possible” when this request is made, as this phrase can mean something different to each of us. Providers need to listen to the message and attend to its meaning, not just to physical symptoms. How We Die sends a powerful message to health care providers of any discipline in the home and institutional settings to really listen to what is being said by the dying and their family.

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Restraint Free Care, 1/2 videocassette/21 min/color/1995.
Producer and distributor, Envision, Inc., 1201 16th Ave.
South, Nashville, TN 37212; 800/230-9110. Sale $275, rent $125 for five days. Program guide included.

Restraint Free Care deals with the challenges of providing safe care without the use of restraints. The video begins with a brief history of restraint use and details the definition of restraints given in the Omnibus-Reconciliation Act (OBRA) of 1990. This act defined two categories of restraints: physical restraints, devices to the body or the environment that restrict voluntary movement, and chemical restraints, the use of medications prescribed specifically for behavioral disturbances rather than for treatment.

The negative effects of restraint use are detailed. The psychosocial problems delineated include social isolation, a sense of being punished, and increased confusion. Unfavorable pathophysiological effects are attributed to immobility and include increased cardiac load, pneumonia, and decubitus ulcers. Ultimately, they note, restraint use is costly because hospital stays are prolonged and treatments are more complex.

The three principal reasons documented for restraint use are fall risk, treatment interference (e.g., removing catheters and endotracheal tubes), and agitation. They note that nurses feel a legal-ethical responsibility in justifying their use of restraints, yet restraints are not an effective means of increasing safety and preventing injury. Research is cited showing that restraint use actually increases the incidence and seriousness of falls.

Regulations governing restraint use from both federal and accrediting agencies are given. This section includes the guidelines from OBRA regulating nursing homes, those of the Joint Commission for the Accreditation of Healthcare Organizations specifying how restraints should be used in acute care settings, and guidelines from the FDA and the Commission on Accreditation of Rehabilitation Facilities. In general, these regulations, a well as standards of practice, oppose restraint use except for emergencies such as protecting staff from intoxicated patients and in suicide prevention. Findings from a survey by the American Association of Homes for the Aging demonstrating the effectiveness of the regulations are presented.

When behavior becomes difficult to manage, the authors suggest assessing the individual patient for unmet needs so that underlying causes might be addressed. A change in health status, a need for pain relief or for fluids, or a desire to go to the bathroom are among the array of possible causes given. Three patient scenarios are discussed where careful observation, assessment, and intervention reduced both confusion, agitation, and frequency of falling.

Suggestions are given for modifying the environment, including maintaining clear paths for walking, providing adequate pain relief, and having rails in the bathroom. The need for institutional changes such as increasing recreational activity and installing door alarms is also discussed. Providing individualized nursing care and devising creative solutions are emphasized.

This informative video provides an excellent overview of the history, issues, and regulations on restraint use. The case scenarios are realistic and portray the complexity of devising successful interventions through careful assessment and reassessment. The preservation of human dignity, freedom, and individuality is a continuous theme throughout the video. Didactic information is formally presented, alternating with patient situations, so that viewer interest is maintained. The program guide provides learning objectives, summarizes information in a slightly different way, includes a brief reference list, and provides a post-test.

Although the narration is done by nursing faculty and nursing clinicians, the video is suitable for other healthcare professionals working in geriatric settings where restraints might be used. If followed by discussion, it would also be suitable as a learning tool for paraprofessional staff in long-term care settings.

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Under-recognition of psychiatric and neuropsychiatric problems by medical professionals is a common problem. Delirium is no exception: This video notes that the rate of misdiagnosis of delirium in a troubling 83%. Recognizing Delirium in the Elder Person is an effort to better educate medical personnel who frequently assess patients with delirium — specifically those who provide emergency medical care.

In a St. Louis University study, only 6 of 38 cases of delirium diagnosed with a structured interview were identified by emergency care professionals. Consequences of misdiagnosis may be fatal. As the video details at its beginning, mortality rates, length of hospitalization, risk of nursing home placement, and functional decline are greater...