

# **GUIDELINES FOR HOSPITAL VISITATION FOR LARYNGECTOMY PATIENTS**

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## INTRODUCTION

Dr. Salmon received her M.A. degree in 1962 and Ph.D. degree in speech pathology in 1965 from University of Iowa, Iowa City, IA. She belongs to many professional organizations and has presented papers at speech workshops throughout the United States and many foreign countries, also at numerous IAL Annual Meetings and IAL Voice Institutes. Dr. Salmon retired after serving over 25 years as speech pathologist at the VA Medical Center in Kansas City.

She has lectured at numerous workshops designed to train teachers of alaryngeal speech and is co-editor of The Artificial Larynx Handbook. In 1979, she was chairman of ad hoc committee to develop state guidelines for hospital visitation training of laryngectomized visitors, sponsored by the Missouri Division Service & Rehabilitation Committee, American Cancer Society at Jefferson City.

She was chairman of the Jackson County Training Workshop for Hospital Visitation, Kansas City Veterans Administration Medical Center, August 18, 1979. She has led alaryngeal speech groups at University of Kansas Medical Center and VAMC, Kansas City, since 1968.

Dr. Salmon has served periodically as an IAL Director-at-Large on the IAL Board and on many committees. She was co-chair of the Rehabilitation Committee in 1982-1983 when the IAL Visitor Training Manual was compiled.,

Shirley served as coordinator for the Directory of Instructors of Alaryngeal Speech 1981-1983. She coordinated voice assessments, speech therapy and exhibits for the IAL Annual Meetings from 1986-1992 and has been a member and consultant to the Heart of America Nu-Voice Club of Kansas City, MO, since 1972.

## FOREWORD

Since these guidelines were first presented to the Twentieth Annual Meeting of the IAL in Kansas City in 1971, they have come to be referred to as "Dr. Salmon's Ten Do's and Don'ts." Possibly because of their simple eloquence and certainly because of their common sense approach to the question, they have enjoyed widespread acceptance among those who feel there is a real need for trained hospital visitors.

It goes without saying, I believe, that these guidelines intelligently applied would produce a better visit to the newly laryngectomized patient than that made today by an untrained visitor.

Executive Secretary  
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that something "different" was said or done with you.

**10** Statements concerning the length of time before your tracheotomy tube was removed, the length of time before your hospital discharge, or your ideas concerning the disadvantages of different methods of speech may be different from information the patient has already received. These differences may only cause uncertainty and doubt in a patient who is already faced with considerable anxiety.

Remember, your purpose in visiting a patient is not to plant seeds of doubt, but rather to relieve his mind and to bolster his spirits.

It is desirable to make at least one follow-up contact after the patient leaves the hospital, either in person, by telephone or by letter. Do it! This will make the patient and spouse feel more as if someone is truly interested in them and will increase the likelihood of their attending the New Voice Club meetings.

## NOTE

This manual was written in the 1970's when the only acceptable speech for a laryngectomee was esophageal. Since that time, with the development of the TEP and improved electro larynxes three methods of speech have been standards for laryngectomees. As you read this manual you should consider reference to esophageal speech to refer to any of the three methods of speech.

**7** Do allow opportunity for speech-reading. No matter what the reason may be, if one is having difficulty hearing a speaker's message, he will try to obtain cues by reading lips and by observing facial expressions. Face the patient when you talk to him and do not seat yourself directly in front of a window when you visit during the day or in front of a bedside light when you visit in the evening. You do not want your listener to have light glaring in his eyes when he is attempting to gain additional information from your lip movements or your facial expression.

**8** Do observe the noise level within the hospital room and try to manipulate around it. You may find it advisable to turn off the television or the radio. You may want to suggest moving to a quieter place if the room is being shared by another patient who has visitors or who is creating competitive noise.

You should not visit during the lunch or supper hours since this is an inconvenient time for hospital personnel. Besides, the clanging of trays in the halls can cause an overriding noise and can also be distracting. Try to observe the regular visiting hours.

**9** You will no doubt be asked lots of questions. Gardner (1971) has detailed many fine suggestions as to what might be said to patients. I would encourage you to read what he has to say. Of course, one can never anticipate all the questions that might be asked. One word of caution. When you provide an answer do be honest. If you don't know the answer, say so!

It might be helpful to suggest some topics which should not be discussed. Do not try to answer questions about surgery or hospital procedures and do not imply criticism about professional workers involved with the patient by suggesting

**1** Do not risk offending a surgeon by visiting his patient in the hospital until the surgeon has requested it or approved it. Remember the doctor has the legal right and the legal responsibility to decide who shall see or not see his patients.

All other hospital personnel (nurses, speech-language pathologists, etc.) must have his approval before they call you and request a visit. Even the family should mention their desire for a visit to him and solicit his approval before you come.

So, it's a good idea for you to remember to ask whoever contacts you whether the doctor has approved the visit. In this way you will not offend the doctor and you will not be committing a faux pas.

Such discourtesies occur more frequently than you would believe. Two examples may sound familiar enough to be convincing.

Consider the laryngectomees who have acquired speech skills and who return to the hospital for periodic check-ups. Following their check-ups they frequently stop by to visit the nurses on the hospital floor where they recuperated from their own surgery. While there they hear about patients in whom they are interested and, unfortunately, begin visiting with them prior to receiving any official request.

A second example may seem even more familiar. It happens when an alaryngeal speaker has received an official request to visit one patient but, while visiting that particular patient, he notices other laryngectomees on the same floor and decides to also visit with them. Unfortunately, he does so without an official request and in so doing commits a courtesy to the surgeon.

**2** Do not enter a patient's room without first stopping at the nurses' desk to introduce yourself to the Head Nurse, to state which patient you would like to see, and to indicate who requested your visit. It is a matter of common courtesy to inform the Head Nurse of your visit since she is responsible for all patients on her floor. It also provides her with an opportunity to note your visit in the patient's hospital chart for the benefit of the surgeon and other hospital employees.

Also, she can be most helpful to you. She knows the condition of the patient and can tell you if the patient is ready to receive visitors and/or if you might wait so as not to interrupt a doctor's visit or a treatment.

**3** When you first introduce yourself to the patient, do present your name card or write down your name, address and telephone number so that he can refer to it later. Similarly, if you are a member of a local laryngectomees club, provide him with written information about it such as the name of it, when and where meetings are held, and some of the typical activities carried out.

At the same time, write down the patient's full name, current address with zip code, and telephone number, including area code. You will want to pass this information on to the New Voice Club and the International Association of Laryngectomees so he can begin receiving newsletters and announcements of meetings. Such information can also be used when you make a follow-up home visit. Be sure to telephone ahead and schedule a convenient appointment time.

Incidentally, because of the new Patient's Privacy laws, you should obtain permission to refer his/her name for any mailing list.

**4** If the patient's spouse is not present, do arrange another appointment that is convenient for you and your spouse, if you are married, to visit with the patient and his or her spouse. We know from several investigators that spouses of laryngectomees often are poorly informed regarding all aspects of the laryngectomy. They need to be provided with information and resented being ignored by those interested in rehabilitation.

**5** For the sake of the patient and yourself, do use your communication skills to your best advantage. Although the incidence of hearing loss in the laryngectomized population has not been systematically investigated, we do know that the average age of individuals when laryngectomized is about 55 or 60 and we do know that the average person this age in our country may well have a hearing loss. So, there is a good possibility that either the patient or the patient's spouse will have some degree of hearing loss.

With this fact in mind about the listener, consider some other facts that we know about esophageal speech. We are aware that the pitch level of esophageal voice makes it more difficult for the human ear to perceive. We are also aware that most esophageal voices are not as loud as normal voices.

Now, considering all three of these factors, it seems logical to conclude that you, as an esophageal speaker, must adapt your speaking behavior in order for it to be as effective as possible. What can you do to compensate for these possible communication hazards?

**6** Do be aware of proximity. Snidecor (1968) and Lanpher (1971) have each reminded us that, "loudness varies in inverse proportion to the square of the distance." That is, a laryngectomee can be heard four times as well when his listener is three feet away as when he is six feet away. If you remember this fact, you will apply it by assuring yourself that the seating arrangement between you, the patient and the spouse assures close proximity.