Service Delivery in Rural Centres of Ontario to Individuals Who Are Laryngectomized

Prestation des services aux personnes qui ont eu une laryngectomie et qui habitent des centres ruraux de l'Ontario

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Abstract

The purpose of this study was to obtain information on the type and scope of services provided to individuals diagnosed and treated for laryngeal malignancy. Information presented is based on survey data gathered from respondents representing small or rural population centres in the province of Ontario, Canada. Information was obtained on the type and number of laryngectomy surgeries performed, interdisciplinary laryngectomy care teams, the availability and extent of pre- and postoperative counselling services, voice and speech rehabilitation options offered, frequency and duration of speech rehabilitation programs, as well as other related services. Results indicate that services are not always available in such centres. The data are discussed relative to the need for such services, as well as the preconceived notion that these services will be available once individuals return to their home centres following medical treatment. As such, these data are interpreted within the context of assessing how comprehensive services are provided, as well as identifying the need for enhanced service provision.

Key words: laryngectomy, laryngeal cancer, rehabilitation, service delivery, health care

The manner and speed with which health care is being provided and the degree of change which has been observed in the 1990s has been remarkable. Budget constraints, an ever-increasing aging population, biomedical advances, increased workloads, isolated service settings, and reduction in support personnel have impacted traditional service delivery models. In addition, fee schedules for medical services which are designed to control billing practices, are felt to reward "curative" practices more so than "preventative" services like individual counselling or group education and support. The health care system has, perhaps unwittingly, focused on "illness" as opposed to "wellness" (Leart & Williams, 1997). In large population centres such changes may culminate in less time for health care providers to "wellness" (Leart & Williams, 1997). In large population centres such changes may culminate in less time for health care providers to approach in working with the persons they treat.

Over the past decade or more there has been considerable interest in service delivery models used in rural communities within Ontario. In 1989, a steering committee was formed to consider a number of proposals for the revision of the Public Hospitals Act (originally proclaimed in 1931). In 1992, this steering committee submitted a report to the Minister of Health, Frances Lankin (Steering Committee, Public Hospitals Act Review, 1992). The report contained six guiding principles and many recommendations for change to the Public Hospitals Act. The first principle noted was "accessible and equitable patient-centered treatment and care." The report acknowledged that "there are practical difficulties in achieving availability, for example in thinly populated areas such as Northern Ontario," yet, while the Act cannot guarantee that hospital and health services are available throughout the province, the importance of "access and equity" was acknowledged. Thus, a renewed commitment to serving the health care needs of all Ontario residents, whether urban or rural, appeared to be emerging. Another stated principle in the Act was "commitment to quality." One positive result of the review was that government agencies increased their efforts to find ways in which
smaller communities could more easily access the services of physicians and other health care professionals, including speech-language pathologists, audiologists, occupational therapists, and physiotherapists (The Rural and Northern Health Care Framework, 1997). However, there are numerous issues and challenges associated with service provision in smaller communities where services may be limited or nonexistent.

Perhaps the predominant issue raised in "Health care facilities in rural and northern areas are fewer and farther apart than those in urban centres" (The Rural and Northern Health Care Framework, 1997, p. 1). Travel distance, particularly during winter months, means access to health care more difficult relative to larger population centres. In addition, smaller communities may find it more challenging to recruit and retain professionals from a variety of disciplines including speech-language pathology. There may also be increased difficulty acquiring equipment to enable professionals to provide the most basic diagnostic and therapeutic services, as well as for meeting professional practice guidelines (The Rural and Northern Health Care Framework, 1997). Despite these significant challenges, a strategy must continue to evolve to better serve rural Ontario's need for accessibility and quality in health care.

So, what is practice like in smaller rural communities? This is determined by many factors such as distance from a major centre, population base, setting (hospital, school, health unit, private sector), facilities/structures in place, and community support. In most instances, an individual requiring specialized medical and/or follow-up treatment would initially receive their care at a larger centre equipped to deal with their needs. The individual would then return to their home community. That long-term follow-up is ultimately assumed to become the responsibility of the patient's home community hospital. The return to rural-based hospital care following an urban critical care stay is likely to become the norm as efforts to reduce the economic strains related to health care continue. The need to travel substantial distances to receive treatment may not be practical or desirable for most patients, particularly if they are still recovering. Further, such an option may not be cost-effective. Ideally, they would be able to continue their recovery in their home community hospital. The return to rural-based hospital care following an urban critical care stay is likely to become the norm as efforts to reduce the economic strains related to health care continue. The need to travel substantial distances to receive treatment may not be practical or desirable for most patients, particularly if they are still recovering. Further, such an option may not be cost-effective. Ideally, they would be able to continue their recovery in their home community hospital. The return to rural-based hospital care following an urban critical care stay is likely to become the norm as efforts to reduce the economic strains related to health care continue. The need to travel substantial distances to receive treatment may not be practical or desirable for most patients, particularly if they are still recovering. Further, such an option may not be cost-effective. Ideally, they would be able to continue their recovery in their home community hospital. The return to rural-based hospital care following an urban critical care stay is likely to become the norm as efforts to reduce the economic strains related to health care continue. The need to travel substantial distances to receive treatment may not be practical or desirable for most patients, particularly if they are still recovering. Further, such an option may not be cost-effective. Ideally, they would be able to continue their recovery in their home community hospital. The return to rural-based hospital care following an urban critical care stay is likely to become the norm as efforts to reduce the economic strains related to health care continue. The need to travel substantial distances to receive treatment may not be practical or desirable for most patients, particularly if they are still recovering. Further, such an option may not be cost-effective. Ideally, they would be able to continue their recovery in their home community hospital. The return to rural-based hospital care following an urban critical care stay is likely to become the norm as efforts to reduce the economic strains related to health care continue. The need to travel substantial distances to receive treatment may not be practical or desirable for most patients, particularly if they are still recovering. Further, such an option may not be cost-effective. Ideally, they would be able to continue their recovery in their home community hospital. The return to rural-based hospital care following an urban critical care stay is likely to become the norm as efforts to reduce the economic strains related to health care continue. The need to travel substantial distances to receive treatment may not be practical or desirable for most patients, particularly if they are still recovering. Further, such an option may not be cost-effective. Ideally, they would be able to continue their recovery in their home community hospital. The return to rural-based hospital care following an urban critical care stay is likely to become the norm as efforts to reduce the economic strains related to health care continue. The need to travel substantial distances to receive treatment may not be practical or desirable for most patients, particularly if they are still recovering. Further, such an option may not be cost-effective. Ideally, they would be able to continue their recovery in their home community hospital. The return to rural-based hospital care following an urban critical care stay is likely to become the norm as efforts to reduce the economic strains related to health care continue. The need to travel substantial distances to receive treatment may not be practical or desirable for most patients, particularly if they are still recovering. Further, such an option ma
Voice restoration. Only one facility (3%) reported providing both procedures for postlaryngectomy voice restoration (Blom & Hamaker, 1996). If laryngectomy services were not performed at the responding facility, recipients were asked to indicate the city, facility, and approximate distance of the hospital where the individual would receive such procedures. Of the 52 responding hospitals, it was identified that surgical treatment was provided in one of seven larger centers (Hamilton, London, Kingston, Ottawa, Toronto, Sudbury, or Thunder Bay) which ranged from 35 to 400 km's from the patient's home community hospital.

Number of Individuals Seen Postoperatively
Respondents were asked to indicate the number of individuals undergoing total laryngectomy who were seen in one year. Seventeen respondents (53%) reported servicing between 1 and 10 individuals with total laryngectomy, while 7 (22%) reported servicing between 1 and 10 individuals with partial laryngectomy. The remaining 8 (25%) facilities indicated that no laryngectomy patients were seen at their facilities.

Laryngectomy Services Available
The types of SLP services available in the responding hospitals were separated into the following categories during data collection: a) education, b) counselling, and c) voice/speech rehabilitation. Results indicated that more respondents provided education, counselling, and voice/speech rehabilitation services on an individual (92%) rather than on a group basis (18%). Tables 1a, 1b, and 1c display the percentages of facilities providing education, counselling, and methods of voice/speech rehabilitation services, respectively.

Interdisciplinary Laryngectomy Care Teams
Only 2/32 respondents reported having formal interdisciplinary laryngectomy care teams in their hospital. Members of the team included SLPs, otolaryngologists, social workers, home care professionals, pastoral care providers, dieticians, and individuals who underwent laryngectomy. Rather than being part of a formal comprehensive team, 11/30 respondents reported close collaboration with physicians, otolaryngologists, dieticians, and others through various methods: a) telephone (53%), b) the professional literature (43%), and c) a team approach (27%).

Types of Laryngectomy Surgery Available
Respondents were asked to identify the types of laryngectomy surgery available at their facility. Thirty of 32 respondents (94%) reported that laryngectomy was not performed at their centers. Of the remaining two (6%), one offered only total laryngectomy surgery to their patients and indicated that all other surgical procedures were performed at other facilities. The remaining hospital performed total, near-total, hemilaryngectomy, supraglottic laryngectomy, and related procedures (e.g., neck dissection). Participants were also asked to report the availability of tracheoesophageal (TE) puncture voice restoration. Only one facility (5%) reported providing both primary (i.e., performed at the time of laryngectomy) and secondary (i.e., performed some time following the laryngectomy) puncture procedures for postlaryngectomy voice restoration (Blom & Hamaker, 1996). If laryngectomy services were not performed at the responding facility, recipients were asked to indicate the city, facility, and approximate distance of the hospital where the individual would receive such procedures. Of the 52 responding hospitals, it was identified that surgical treatment was provided in one of seven larger centers (Hamilton, London, Kingston, Ottawa, Toronto, Sudbury, or Thunder Bay) which ranged from 35 to 400 km's from the patient's home community hospital.

Results
Of 45 surveys distributed to hospitals, a total of 32 (71%) were completed and returned by August 1998. The average population 'each basin' for responding facilities was 84,000 people. That is, each center surveyed was asked to indicate the approximate population base for which they potentially could provide health care services. The results gathered and summarized herein are from the 32 responding Ontario hospitals. Ten of the responding hospitals (31%) indicated that SLP services for individuals who had a laryngectomy were not currently available through their facilities. The remaining 22 (69%) centers reported providing SLP services, but only 20 (62%) reported seeing laryngectomy patients.

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<table>
<thead>
<tr>
<th>Types of Laryngectomy Surgery Available</th>
<th>Number of Respondents</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Total laryngectomy</td>
<td>20/21</td>
<td>95%</td>
</tr>
<tr>
<td>Near-total laryngectomy</td>
<td>6/21</td>
<td>29%</td>
</tr>
<tr>
<td>Hemilaryngectomy</td>
<td>7/21</td>
<td>33%</td>
</tr>
<tr>
<td>Supraglottic laryngectomy</td>
<td>9/21</td>
<td>43%</td>
</tr>
<tr>
<td>Other procedures</td>
<td>6/21</td>
<td>29%</td>
</tr>
</tbody>
</table>

Table 1a. Types of education services available for those undergoing laryngectomy and the percentage of facilities providing these services.

<table>
<thead>
<tr>
<th>Services Available</th>
<th>Number of Respondents</th>
<th>Percentage of Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative information</td>
<td>19/21</td>
<td>90%</td>
</tr>
<tr>
<td>Postoperative Information</td>
<td>7/21</td>
<td>33%</td>
</tr>
<tr>
<td>Voice/Speech Rehabilitation Options</td>
<td>9/21</td>
<td>43%</td>
</tr>
</tbody>
</table>

Table 1b. Services available education for those undergoing laryngectomy and the percentage of facilities providing these services.

<table>
<thead>
<tr>
<th>Education Area</th>
<th>Number of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative information</td>
<td>19/21</td>
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Table 1c. Education services available for those undergoing laryngectomy and the percentage of facilities providing these services.
other professionals when treating laryngectomy patients. Individual professions identified in the collaboration were otolaryngology (4/11), other medical doctor, nurse, social worker, physical therapist, dietician (3/11), other SLPs (2/11), and occupational therapists (1/11).

Professionals Providing Preoperative Care

Respondents identified several professionals as being involved in the provision of preoperative care in the area of: a) information on surgery/treatment options, b) voice/speech rehabilitation and related communication information, and c) counselling of patients undergoing laryngectomy surgery. Data indicated that a few disciplines were the primary providers of specific preoperative services (e.g., otolaryngology, SLP, other physician). Several respondents reported providing additional preoperative services to laryngectomized individuals. These included medic alert information, information on additional laryngectomy aids, specific stoma care information, and information on support groups. In addition, respondents from two facilities identified pastoral care workers as being involved in the provision of counselling, while one respondent indicated the involvement of former patients. Table 2 displays the percentages of hospitals providing these preoperative services and the professionals involved in the provision of such services. When preoperative information was not provided by the responding facility, recipients were asked to indicate the facilities where such services were provided. This request resulted in that in all instances, such information was provided in larger centers (Hamilton, Kingston, London, Ottawa, Sudbury, and Toronto). In regard to the type of services requested from these larger centers, 23 respondents indicated they referred for surgical treatment information, 20 for voice and speech rehabilitation options and information, 17 for counselling, and 11 for other reasons.

Immediate Postoperative Care

Respondents were asked to identify those professionals who provided immediate postoperative care to laryngectomized patients at their facility. Of the 32 respondents, only 8 (25%) reported providing such information. Table 3 shows those professionals providing immediate postoperative care to laryngectomized patients in regard to stoma care, counselling, TE puncture care, arytenoid voice and speech training, information on support groups and other resources, and information on new voice options.

Long-Term Postoperative Care

A number of respondents indicated that their facility provided long-term postoperative care to laryngectomized patients. Regarding stoma care at the one-month post operative stage, 45% of respondents reported that this service was available at their facility. 35% continued to provide this service at the 2-6 month postoperative stage, while only 20% provided information on stoma care at the 7-12 months postoperatively. TE puncture care at the one-month postoperative stage was offered by only 15% of respondents. During the 2-6 month postoperative period, 20% offered this service while only 10% provided TE puncture care services to their patients at the 7-12 month postoperative stage.

Some form of counselling was provided by 65% of respondents in the one-month postoperative stage. This remained relatively constant throughout the 2-6, and 7-12 month postoperative periods. Sixty percent of respondents provided counselling 2-6 months postoperatively, while 55% offered this service 7-12 months postoperatively. Information regarding postoperative voice options was provided by 65% of respondents at all three postoperative periods (1 month, 2-6 and 7-12 months). Voice-speech rehabilitation at the one month postoperative period was offered by 85% of respondents, while 65% reported providing voice-speech rehabilitation during the 2-6, and 7-12 month postoperative periods.

Information on support groups and other resources was provided by 70% of the respondents at 1 month and 2-6 month postoperative periods. 65% indicated that they provided information on support groups at the 7-12 months postoperative stage. When asked to indicate whether similar services were offered at private clinics or rehabilitation centres in their respective geographic areas, the percentages of hospitals providing these services and the professionals involved in the provision of such services were similar to those reported for the larger centers.
areas, 19% of respondents indicated that these services were available elsewhere; 73% reported services were not available at other centers in the area, and 8% responded that they "did not know."

Methods of Providing Information

Voice/Speech Rehabilitation Options
Respondents reported using various methods of providing information on voice/speech rehabilitation options to laryngectomized patients. Pamphlets were used by 19/22 of the respondents; 16/22 reported presentation of information by SLPs, while 14/22 employed video presentations. Visits by individuals who had a laryngectomy and who used various methods of alaryngeal speech was reported by 9/22 respondents.

Voice and Speech Rehabilitation
Ninety-one percent of respondents reported conducting voice-speech rehabilitation on an individual basis while 18% employed group therapy. Fourteen percent specified other settings in which voice-speech rehabilitation sessions were conducted (e.g., home care, with the patient and his/her family, and through a "New Voice Group").

Duration, Frequency and Length of Voice-Speech Rehabilitation Sessions
Four of 20 respondents indicated that voice-speech rehabilitation services were not offered at their facilities. When asked to identify the typical duration of voice-speech rehabilitation sessions for laryngectomy patients, 3/20 reported a typical duration of less than one month; 7/20 reported durations of 1-3 months, and 7/20 reported 3-6 months. Four centres reported providing service for 7-12 months postoperatively, but no facility reported a duration of more than one year. When voice-speech rehabilitation services were offered, respondents were asked to indicate the typical frequency of appointments. When conducting sessions focusing on TE speech, 3/5 reported holding sessions more than once weekly and 2/5 reported using one session weekly. When providing instruction in esophageal speech, 9/15 indicated that more than one session per week was required, but only 1/15 reported holding sessions more than once per week. Instruction in the use of artificial laryngeal devices typically required more than one session weekly according to 7/19 respondents, while 14/19 held sessions once per week.

In regard to the typical length of voice-speech rehabilitation appointments, 33% of respondents reported one-hour sessions; 16/21 indicated that the typical duration of appointments was between 30-60 minutes; 1/21 reported requiring less than 30 minutes per session.

Recommendations Following Voice-Speech Rehabilitation
Respondents were also asked to identify what recommendations were made to laryngectomized patients following the completion of voice-speech rehabilitation. Of the 17 (81%) respondents, 13 reported discharging patients with some type of follow-up services (e.g., home care, home programming, and/or support groups); four reported simply discharging without follow-up. Forty-eight percent of respondents indicated that patients were provided with home programming materials, while others received follow-up services through home care (29%) or private facilities (5%); 24% of respondents identified additional suggestions for their patients (e.g., laryngectomy support groups and contacting the facility whenever necessary) following discharge from formal speech treatment.
Discussion

The purpose of the present study was to obtain more detailed information on service provision in small, urban, and remote population centres in Ontario. While earlier work by Allen, et al. (1998) examined the nature of laryngectomy services in major facilities across Canada, concerns about smaller centres were raised. Based on the findings of Allen, et al. (1998) it was suggested that smaller communities might offer more comprehensive services for laryngectomy treatment as a result of increased time for patient care, clearly identified case managers, and reduced caseloads. As an addendum to Allen et al’s work, the present study sought to provide information regarding laryngectomy services in smaller health care centres in Ontario.

The present study achieved a return rate of 71% (i.e., 32/45). This response rate was acceptable and may indicate that the results obtained are likely representative of service delivery trends in smaller hospitals throughout Ontario. Hence, some general trends are noted and specific concerns raised.

Laryngectomy Services Available

As one might expect, 94% of respondents reported that no laryngectomy services were performed at their centres. Only two of 32 centres stated that their centre offered laryngectomy surgery. These findings are consistent with the notion that centres in smaller communities may not have direct access to the equipment, skilled professionals, and/or funding necessary for performing such extensive surgeries. Respondents reported that although surgeries were not performed at their centres (30/32), service provision beyond the immediate postoperative period was provided for individuals with laryngectomy. Ten of 32 respondents stated that no services were offered postoperatively for individuals with laryngectomy. More than half of the responding centres reported seeing between one and 10 individuals who had undergone total laryngectomy, and another 22% reported serving between one and ten individuals with partial laryngectomy annually. The context within which these clients are seen postoperatively is on an individual basis (91%), as opposed to a group setting. This would be expected within the limited number of individuals with laryngectomy who are seen in the hospitals of smaller cities. Fewer numbers of patients/clients present a challenge in developing effective groupings for speech rehabilitation. In addition, the sporadic nature of referrals from larger centres may mean that individuals are not always ready to enter group therapy at the same time.

Types of Services Available to Individuals with Laryngectomy

The majority of respondents appeared to provide some form of education, counselling, and voice/speech rehabilitation services. Perhaps not surprisingly, 95% of those surveyed reported that they provided education information in the postoperative period. In addition, 80% of those surveyed provided some form of counselling in the same period. This is reassuring given that both education and counselling are critical in the postoperative period. Because the period of time prior to surgery is often brief and the patient’s emotional state may be heightened, information presented pre-operatively may need to be reiterated postoperatively.

Unlike the larger centres, where education and preoperative counselling are prominent, the role of respondents in the smaller centres, as evidenced by our numbers, may be to provide services postoperatively. This is due to the fact that surgery may be preferred in a larger centre with follow-up postoperative services delivered in the patient’s home community. In many instances, this may be a population centre that is quite small or remote. It is interesting to note that relative to the findings by Allen, et al. (1998), the current
study suggests levels of preoperative education and counselling report by the smaller centres is less than that provided by the larger centres. That is, in comparing small to large centres, 29% versus 69% provided preoperative education, and 25% versus 92% provided preoperative counselling, respectively. Therefore, there are large differences between small and larger centres when preoperative education and counselling services are considered. More noteworthy however, is that the postoperative figures for education and counselling are similar (e.g., for small to large, 95% versus 100% for education, and 80% versus 100% for counselling). The majority of voice services are provided on an individual basis (e.g., 95%) in the smaller centres. This is similar to what has been noted to occur in the larger centres. Therefore, for both small and large centres it appears that the method of choice for dispensing information is clearly on an individual basis.

While the present data are not comprehensive, some concern is raised regarding the finding that counselling services were provided to families in only 70% of the smaller centres surveyed. Given that the caregivers/family/peer support of the laryngectomized individual is so crucial to one's emotional well-being, physical adjustment, and positive self-concept, it would be preferable to see a higher percentage of respondents offering these services. However, it is also clear that counselling services are often reported anecdotally across a variety of communicative disorders. This suggests that clear efforts to expand the counselling role of other professionals is necessary.

With reference to postoperative voice and speech rehabilitation, it was found that the electronic artificial larynx was the primary mode of alaryngeal communication followed by oesophageal speech in the smaller centres; tracheoesophageal (TE) speech took place in only 27% of smaller centres. The fact that the artificial larynx continues to predominate may be due to several factors including clinician familiarity with this alaryngeal mode of communication, the ease of implementation, reduced time in training the client, and fewer complications. Additionally, the overall reduction in health care dollars continues to be a continuing problem that impacts service provision. Because the artificial larynx is a well-established mode of alaryngeal communication, it may be more appealing as a therapeutic option for clinicians who have less training and experience in the area of counselling services.

Long-term postoperative care is primarily in the hands of the SLP in the smaller centres, with 75% of the time, the SLP appeared to be one of the few devices with which the clinician had received training during graduate school.

The emergence of TE puncture as a relatively new procedure may have led to the fact that professionals in smaller centres may not possess sufficient education or training or materials in this area. Because the artificial larynx is a well-established mode of alaryngeal communication, it may be more appealing as a therapeutic option to clinicians who have less training and experience in the area of postlaryngectomy speech rehabilitation. It is important to note that TE puncture voice restoration may require a secondary surgery if not done at the time of laryngectomy. This may reduce its consideration as an alaryngeal mode by clients living in smaller or rural areas, as they would have to travel to a larger centre to have the procedure done.

Interdisciplinary Teams

It appears that the lack of interdisciplinary teams (Allen et al., 1998), is not inherent solely to the large health care centres. In the present study, only 6% of respondents reported having formal laryngectomy care teams within their hospital. Although only two of the 32 respondents reported having such teams, 11 (37%) indicated that while they did not have a formal laryngectomy care team, they collaborated closely with other professionals (e.g., nursing, social work, physiotherapy, physician, occupational therapy, dietitian, and other SLPs). Several reasons may account for these findings: there may be a lack of skilled healthcare professionals within smaller centres due to recruitment issues and budget constraints. Further, the number of individuals referred to smaller centres may not justify the existence of a formal laryngectomy team.

Professionals Providing Preoperative Care

In terms of options for surgical treatment, voice and speech rehabilitation, and counselling, respondents indicated that postoperative information was provided by another facility in 82%, 68%, and 60% of the cases respectively. This is consistent with the previous findings that preoperative care is handled primarily by professionals in larger centres (Allen et al., 1998). Of all professionals identified, the otolaryngologist most often provided the surgery treatment options and information (36%); this trend was also noted by Allen et al. (1998). When voice/speech rehabilitation options and counselling were provided in the smaller facilities, the provision of this information was more often offered by the SLP (50%) and (41%), respectively.

Speech-Language Pathology Services

The role of the SLP in the postoperative period was primarily in voice remaining (100%) while presenting information on other voice options also was an area of expertise provided by the SLP (88%). Other information provided by the SLP included support group information (65%), stoma care (25%), counselling (13%) and TE puncture (13%). With the exception of stoma care, where nurses were involved 75% of the time, the SLP appeared to be one of the primary professionals providing all aspects of postoperative care. The burden of counselling and TE puncture information fell to several professionals including nurses, pastoral care, social workers, and otolaryngologists.

Long-Term Postoperative Care

Long-term postoperative education and counselling were services that figured prominently in laryngectomy care offered by the respondents in smaller centres. Intuitively, this might be expected as the needs of the individuals with laryngectomy change throughout the
course of their care. Initially, the immediate needs of patients are predominantly addressed via didactic means (e.g., training in the care of TE puncture and stoma). However, the long-term effects of radical surgery (e.g., lifestyle changes, stigma of having cancer and subsequent surgery, altered self-perception, loss of voice/identity, artificial voice) mean that the patients' needs are not to easily met by service delivery models aimed at reducing costs by expediting discharge. The present results suggest that respondents in smaller facilities 'pick up where the larger facilities leave off.' Thus, counselling, support groups, postoperative voice options and voice speech rehabilitation ultimately appear to become the responsibility of the patient's home community hospital. It is important to note that the majority of this support is offered in the one month postoperative stage. This high level of support may be indicative of the support individuals are believed to need in making a smooth transition from larger to smaller centres.

The finding that 91% of respondents reported providing voice-speech rehabilitation on an individual basis as opposed to group sessions is worth considering. While this finding may be the result of personal preference in providing treatment for patients with laryngectomy, it is possible that there are not sufficient numbers or individuals who are at the same point at the same time in their course of treatment to form a group.

Conclusions

In conclusion, this survey sought to determine the type, accessibility, and breadth of pre- and postoperative services and surgery options available to persons undergoing laryngectomy in 45 smaller communities in Ontario with populations greater than 5,000 and less than 80,000. It is important to note that for the purposes of this preliminary study, only SLP departments in smaller hospitals were surveyed. For this reason, results from this body of work are not easily generalized to other facilities that may offer similar services (e.g., Community Care Access Centres, health units, private practices).

However, from respondents surveyed, certain trends emerged. It appeared that services in smaller facilities were limited during the preoperative and immediate postoperative periods. The burden of providing long-term postoperative care (e.g., counselling, support groups, voice-speech options and rehabilitation) seems to fall to these smaller communities. While individuals may feel that larger centres are able to meet their immediate surgical needs, speech-language pathologists and other professionals in smaller centres provide the care. This high level of support may be indicative of the support individuals are believed to need in making a smooth transition from larger to smaller centres.

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However, from respondents surveyed, certain trends emerged. It appeared that services in smaller facilities were limited during the preoperative and immediate postoperative periods. The burden of providing long-term postoperative care (e.g., counselling, support groups, voice-speech options and rehabilitation) seems to fall to these smaller communities. While individuals may feel that larger centres are able to meet their immediate surgical needs, speech-language pathologists and other professionals in smaller centres provide the care. This high level of support may be indicative of the support individuals are believed to need in making a smooth transition from larger to smaller centres.

The finding that 91% of respondents reported providing voice-speech rehabilitation on an individual basis as opposed to group sessions is worth considering. While this finding may be the result of personal preference in providing treatment for patients with laryngectomy, it is possible that there are not sufficient numbers or individuals who are at the same point at the same time in their course of treatment to form a group.

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