LARYNGECTOMY IS NOT A TRAGEDY

AN INTRODUCTION TO PHARYNGEAL SPEECH

Sydney Norgate

Foreword by L.F.W. Salmon MBE

Churchill Livingstone

Laryngectomy is not a tragedy

(An introduction to pharyngeal speech)

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L. F. W. Salmon
MBE MS MB BS FRCS MRCS LRCP
Consultant Throat and Ear
Surgeon Emeritus, Guy's
Hospital; Past President,
British Association of
Otolaryngologists

CHURCHILL LIVINGSTONE
EDINBURGH LONDON MELBOURNE AND NEW YORK 1984

CHURCHILL LIVINGSTONE
Medical Division of Longman Group Limited

Distributed in the United States of America by
Churchill Livingstone Inc., 1560 Broadway, New
York, N.Y. 10036, and by associated companies,
branches and representatives throughout the world.

First published 1984

ISBN 0 443 02852 4

British Library Cataloguing in Publication Data
Norgate, Sydney
Laryngectomy is not a tragedy.
1. Artificial larynx
2. Laryngectomy
I. Title
617'.533059 RF538

Library of Congress Cataloging in Publication Data
Norgate, Sydney.
Laryngectomy is not a tragedy.
1. Laryngectomees—Rehabilitation. 2. Speech,
Alaryngeal. I. Title [DNLM:
1. Laryngectomy—Rehabilitation—Personal narratives.
2. Laryngectomy—Rehabilitation—Popular works.
3. Speech, Alaryngeal—Personal narratives.
4. Speech, Alaryngeal—Popular works.
WV 540 N838L]
RF540.N66 1983 617'.53301 83–14388

Printed in Singapore by The Print House (Pte) Ltd

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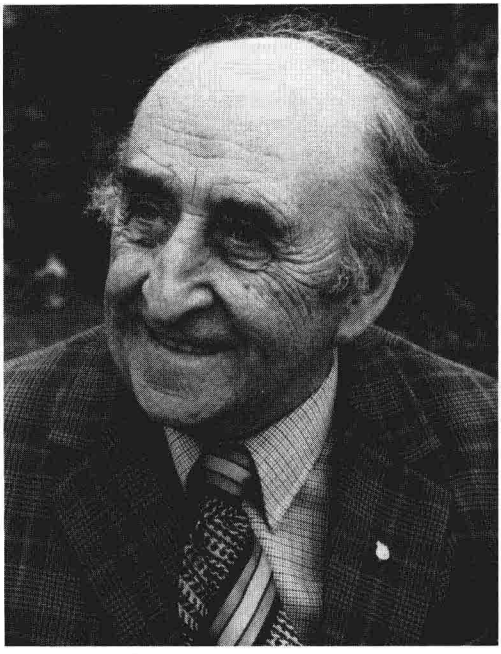

The author 23 months after laryngectomy. On his lapel is the membership badge of the International Association of Laryngectomees.

Foreword

The doctor-patient relationship operates to the advantage of both parties, although the patient rarely recognizes it. Few doctors would maintain their morale without the example and encouragement provided by many of the often seriously ill and disabled people for whom they care. For example, the throat specialist is from time to time faced with the need to confront someone, usually a man in late middle age, with a particularly grim choice; either to accept the sacrifice of his larynx, the principal organ of speech, or to reconcile himself to a long and distressing illness with the probability of a fatal outcome. The majority of such patients, after who knows what agonies of mind, accept the operation and join the ranks of those we call the laryngectomees. Thankfully, the surgeon concerned is supported by the knowledge that almost certainly his patient will come through this surgical ordeal with far less upset than he anticipated, may well return to his job, will almost certainly regain his ability to communicate by speech and, not least, will set everyone around him an example of good humoured fortitude. That this may be expected has been well known for a long time. It is 45 years since one of the great American authorities on this problem described these patients as 'a most optimistic, cheerful group' and every throat surgeon since has gladly echoed this opinion. If there is a body of disabled patients capable of reviving the weary doctor's faith in the indomitable capacity of the human spirit, it is the laryngectomees.

One such is the author of this book and no one illustrates their characteristics better than he does. If a sense of humour is an ability to laugh at oneself, then Sydney Norgate can claim to possess it in plenty. I hope and believe that this monograph will be read by many with no more than a general interest in the subject and I am confident that these readers will enjoy it without regard to the technicalities. No doubt, however, it will find its way into the hands of speech therapists and other professionals who may feel challenged by two considerations. First, that here is someone, unqualified in this specialized field, setting out to instruct patients in matters that they, the speech therapists, with much experience, are bound to understand better than he does; and second, that a number of his opinions run counter to the generally accepted views concerning the voice after laryngectomy.

Most certainly the author is not a trained paramedical and his choice of language, particularly his way of describing certain anatomical and physiological details, betrays this. However, I hope the specialist reader will not allow this to distract him or her (most speech therapists require the latter pronoun) since there are weighty considerations on the other side of the account. It must not be overlooked that the author has himself experienced laryngectomy and its consequences and that his story has the virtue of autobiography. Moreover it is quite clear to me that he has set about understanding and mastering his disability with a degree of concentration and keenness of observation that is truly remarkable — perhaps unique. The experiments with the whistle and blowing up a balloon, for instance, are new to me and worthy of careful objective study. I hope someone will undertake this.

But there is another point needs making also in this connection. For more than 60 years it has been recognized that while many patients after laryngectomy acquire spontaneously the ability to produce voice, often with remarkable success, others do not. The first suggestion that these others could be expected to benefit from a definite course of vocal instruction came from W. W. Morrison in the U.S.A. in 1931 and now the pendulum has swung to a point where it is commonly supposed that no laryngectomee can be expected to make progress without such

help. Sydney Norgate does well to remind us of what every laryngologist knows, that is of the tendency for the laryngectomee to acquire voice in the way that the infant does, not by being told how to but by discovering how to.

I have heard that his advocacy of my suggestion that it is misleading to call his voice oesophageal has exposed him to the scorn of the orthodox. I am sorry. It has always seemed to me that 'oesophageal speech' is a misnomer even in the case of those many laryngectomees who produce it after swallowing air so as to produce sound by eructation. All of us happily normal speakers produce voice with air forced through the vocal cords from the lungs but we do not call this pulmonary speech. The vicarious vocal cords, if they may be so called, that produce sound in the laryngectomee are somewhere in the depths of the pharynx. However, in the case in question, it seems unlikely that the oesophagus plays any part at all and this is why the pharyngeal speech of Sydney Norgate needs special investigation.

I have praised laryngectomees for remaining cheerful and resolute in adversity and gratefully acknowledge the debt their doctors owe them, but there is a third reason why they deserve praise and thanks. They play an essential part in the management of laryngectomees-in-prospect.

Consider these events. The case has been diagnosed, the facts have been laid before whoever is nearest and dearest and then, with all possible compassion, the patient has been told the facts and of the decision he must make. His imagination fails him when he tries to grasp his circumstances after the operation and he is fearfully inclined to give up the struggle and resign himself to the end. This is when the surgeon-in-charge turns to his panel of trusted allies, one of whom can always be relied upon, at this critical moment, to stem the tide of despair, provide reassuring answers to most of the doubts and help the patient to find the courage to say yes to surgery. He asks for a volunteer, from among those patients who have already trodden this painful path, to visit the patient and comfort him with reality. This intervention always succeeds and, that it does, is the ultimate tribute to that ebullient and selfless band, the laryngectomees.

The author of this inspiring little book mentions his own rôle in this last respect almost in passing when he tells us the stories of Eddie and Brian, so that it is left to us to form our own assessment of just how much his pre-operative counselling and example must have meant to these two men.

I shall sum up my opinion of Sydney Norgate by stating my belief that he belongs to that breed from which the Douglas Baders of our race from time to time rise up and, although he would heartily and with true modesty seek to deny the comparison, what follows provides, I am sure, moving and convincing evidence of it.

London, 1984 L.F.W.S.

Preface

After laryngectomy, my body reacted to the new conditions in such a remarkable and co-operative manner that I was compelled to record the new sensations, the effect on my fellow men and how speech came to me again. I had been given a second opportunity to experience hopes and fears, aspirations and disappointments and finally the thrill of achievement so often reserved for the young. How wonderful this was compared with the 'second childhood' usually associated with my age group. I do not believe as Alexander Pope suggested that 'life is a long disease' but I do believe that when a person stops struggling, that person dies. What finer struggle could there be than this effort, with nature as a powerful ally, to regain and maintain pride and dignity and become what a laryngectomee should be—a perfectly ordinary person who has a strange voice and breathes differently from most others.

The path to rehabilitation is a joyous adventure and I will never cease to be grateful to the surgeon and nursing staff of Simpson Ward in The Royal Halifax Infirmary who made it possible. As you will appreciate from the text, the surgeon does not remove the sense of humour along with the vocal cords; in fact he removes nothing vital to the patient's needs. If there were leagues for disabilities, then laryngectomy would be in danger of relegation from the Fourth Division once some form of effective speech had been achieved.

I would define as effective any speech which enables communication to be maintained in an intelligent manner. I would quite emphatically place consonant speech as described in the text in this category. With practice it is possible to carry on long conversations using consonant speech. Indeed Brian, whom I had counselled, chaired a business meeting the day after he was discharged from hospital, only four weeks after surgery. Fellow committee members who had expected him to arrive dumb were considerably surprised to find that he was determined to carry on as usual.

Among laryngectomees, I have encountered some disquiet about those who fail to regain speech of any sort in the absence of any physical explanation and I have wondered if the manner of approaching the problem could be the reason. I have found that four days after surgery simple words like 'cheers,' 'twitchgrass' or the name of a loved one are well within the capabilities of patients. I believe quite firmly that no patient who speaks at that stage can possibly fail to learn at least consonant speech even if full voice is beyond him. If the voice thus produced can be taped and played for the benefit of near relations, then the joyful ride to rehabilitation will have begun.

On this adventurous journey there is no turning back. Is it possible that sometimes communication has been sacrificed at the altar of a God called Voice for so long that it is too late to recapture the possibility of speech of any kind? In putting this question I aim to focus attention on the plight that my fellow laryngectomees may find themselves in, and hope that my experience will give them hope. On a much more cheerful note I was very amused recently to read that whales breathe in a manner very similar to laryngectomees and wondered if a corollary of this would be the assumption that we laryngectomees are having a whale of a time.

I cannot conclude without paying a tribute to Charles R. Nelson, the American pioneer who conquered silence in 1949 and then helped many others to learn speech by writing an instruction book which is still in use in many parts of the world. I believe that my work is a progression from that book

Having a whale of a time!

and sincerely hope that my efforts will create a worthwhile structure built on the excellent foundation he laid and that professional speech assistants all over the world will find it both amusing and helpful.

Halifax 1984 Sydney Norgate

The Man Who Conquered Cancer
Bob Champion riding Aldiniti to victory in The Grand National at Aintree, 15 months after being cured of cancer.
Bob says:
I wish every success to yourself and laryngectomees all over the world and sincerely hope that this book will assist them to acquire the technique required for speech.

The Man Who Conquered Silence
The author leading in his two-year-old winner, Ziparib, at Haydock Park, months after laryngectomy.
The author says:
I may look thoughtful in the photograph but leading in a home-bred winner is more serious than a laryngectomy (at the time!).

Acknowledgements

I wish to record my thanks to the following people and organisations for their help in providing illustrative material used in this book:

Morris of the Yorkshire Post for the cartoons.
Alec Russell for permission to reproduce the photograph of Bob Champion and Aldaniti.
The Literary Trustees of Walter de la Mare and The Society of Authors for permission to use extracts from 'Off the Ground'.

Jim Moran Photography, Halifax.
Provincial Press Agency, Southport.
Yorkshire Post Newspapers Limited, Leeds.

Dedication
This work is dedicated to my wife, Lucy, who made it all possible.

Royalties
Half of the royalties from this book will go to the Royal College of Surgeons of England as a tribute to Mr R. T. Watson and his surgeon colleagues, the dedicated medical few to whom so many patients owe so much.

Author's Note

Pharyngeal or Oesophageal?

The whole of this book is a factual account of the experiences, experiments and ideas of the author. It has been read for medical accuracy by the very eminent surgeon Mr L. F. W. Salmon and in this connection I met Mr Salmon on August 25th 1982. During our conversation I realised that oesophageal speech, the terminology I had used up to that time, did not describe accurately the speech I had learned and which is discussed in this book. It does appear that the gullet itself plays little or no part in the production of my speech whereas the muscles in the pharynx where this voice seems to originate are very important. On this premise then I suggest that such speech can accurately be described as pharyngeal speech.

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