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**A Day in the Life of a
Clinical Speech-Language Pathologist**

**by
Mackenzie Steger**

**A Senior Thesis Submitted to the
Eastern Michigan University
Honors Program
In Partial Fulfillment of the Requirements for Graduation
With Honors in Special Education**

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“A Day in the Life of a Clinical Speech-Language Pathologist”

Over the course of my time spent at Eastern Michigan University, with an involvement in the special education program, I have had the opportunity to listen, observe, and learn about the therapeutic responsibilities of a Speech-Language Pathologist. The past two years have been a huge learning experience for me. I have begun the process of transition from adolescence to adulthood with a concentration on speech-language pathology, studying the variety of communication difficulties that impact our world today. Communication is a critical component of everyday life that is crucial to every person's survival. There are many different forms of communication, but ones that we involve much of our focus on as Speech-Language Pathologists are disorders that disrupt a person's speaking abilities.

To become a great clinician, knowledge of the processes of speech, anatomy, and treatment are critical. Speech is a characteristic of the human race alone. The voice is known as the most powerful communication tool which serves as melody for our speech. Speech is produced at the mouth but created from the vibration of the vocal folds in the larynx. Any sort of malfunction with the vocal folds or laryngeal mechanism can put a person at risk for a speech disorder.

During the course of this semester, I had the privilege of shadowing Instructor of Voice Marc Haxer on what it is like to live the life of a clinical Speech-Language Pathologist in the hospital setting. Mr. Haxer works at the University of Michigan Medical Center in the Departments of Speech-Language Pathology and Otolaryngology/Head and Neck Surgery. While visiting the hospital, and in correspondence to additional observations and knowledge gained over the past few years, I have been able to visualize what a typical day would be like for

a professional in the area of study I wish to continue my future with.

I had been in to watch Mr. Haxer and observe therapy before, but not on such a hectic and stressful day as this one in particular. My first visit wasn't as long, so I was only able to observe a few patients. I noticed the setting in the small room, the bigger and more comfortable chair where the patient sat, and the availability of tongue depressors, food, and water used for different therapy exercises. I could hear other patients doing some singing warm-ups down the hall. Mr. Haxer spent quality time with his own patients and often used humor to inspire them during sessions. He gave many compliments, such as "good for you," "that's hard," and "I'm impressed," and was very motivational as well.

Two patients that I thought were more interesting to watch were both men with tumors. One had a tumor on his right tonsil. Mr. Haxer made him do a few exercises with his tongue by pulling it back, swallowing with the tongue anchored anteriorly, and yawning, to name a few. These exercises helped increase the strength in the base of the tongue. For this one particular patient, Mr. Haxer fed him crackers and guided him in the use of an "effortful swallow" to practice improved tongue base retraction when eating. This activity is especially helpful when the patient is aware of which foods are problematic. By over exaggerating a forced swallow, the patient widens the space of the epiglottis and increases tongue base retraction during the swallow.

The second tumor patient had a small tumor on the right side of his tongue. There was a piece of his arm skin, known as a flap, placed into his mouth post-surgery, which replaced the resected tongue. I got to look into his mouth to see the bumpy and fatty looking tissue. The whole right side of his tongue was discolored (not pink) to his skin tone from the arm flap and scars were present from the surgery. When surgical procedures like this occur with oral cancer

patients, the presence of the flap can diminish the movement of the tongue when speaking, resulting in a need for articulation therapy. In such surgeries, reduced lingual movement can also be present during deglutition.

Mr. Haxer talked about “ear training,” and how self awareness and self correction can be the hardest thing for the patient to accomplish in articulation therapy. Together they practiced tongue twisters, story tellings, and different facilitating techniques to train the tongue. For homework, Mr. Haxer assigned his patient to practice exercises concentrating on his /s/ sound in specific contexts he felt comfortable with, such as on the phone. After the session, a dictation of the client’s status, therapy, and goals was reported via phone into the patient’s computerized chart.

Seeing some of these patients before the official day-long visit at the hospital was most helpful. As intriguing as these observation were, I was completely unaware of the day that was to soon be ahead of me. I was excited that I was able to see a variety of different patients and luckily for me, I was also able to see how as a clinician, you have to learn to adapt for anything to happen. For confidentiality reasons, none of the patients’ names are used in the descriptions that follow.

I arrived at the University of Michigan Medical Center, fed and prepared for a day of observation. Mr. Haxer had already seen two in-patients as I had waited for him to begin his sessions. We walked into his office, where I sat to observe each patient. It was a small room, the same as I had remembered before. I did notice a difference in the amount of utensils already laid out on the counters. It made me feel like I was in my doctor’s office for a check up. I guess maybe I was more surprised because most of my other observations had been done at Eastern’s clinic or through school systems. Most of their ‘tools’ consist of toys, games, and workbooks. I

simply sat off to the side while Haxer went normally about his day, referring to me with specific observations and lessons.

The first client was a young singer who had nodules on her vocal folds. This means she had a thickening of the top most layers of the vocal folds causing a loss in upper range and somewhat hoarse and breathy voice with increased effort in speaking voice towards the end of the day. Like done in previous sessions, together Mr. Haxer and the singer went through humming exercises, easy and effortless glides, and vocalized “ah” to open the larynx and “mm” to narrow the opening and produce frontal resonance. Mr. Haxer recommended that she use resonance voice, with decreased vocal effort, and to stay away from the upper range.

Breath support was also a key for this patient. It was emphasized that she, as well as most other patients, focus on what the body does as they take in a breath. Mr. Haxer stressed how it is important to ask a patient “how did that feel” because they are not always going to know how they sound. Concentrating on the body takes listening to the voice “out of the picture,” and enables the patient to focus on levels of increased body tension. Some of the breathing exercises they did included taking easy and then powerful deep breaths and chanting scales and arpeggios in the mid-range of singing voice.

We quickly moved into the next appointment with a woman who claimed to have continued swallowing irritation. She had received a tonsillectomy within the previous year and felt the progression of a “picking” on the left side of her throat to a “lodging” sensation. She related elevated levels of stress secondary to these sensations. Stress and fatigue can both adversely affect the throat area. Even in class, Mr. Haxer stated how if your body is sick or fatigued, than your voice and swallow mechanisms are sick and fatigued as well. With the large amounts of stress in this woman’s life, a videofluoroscopy, using barium to coat the food, was

performed on the swallow mechanism. This was particularly exciting for me because I got to travel down to GI Radiology to watch first hand how to conduct the videofluoroscopy.

Depending on the patient, there are many different ways to do the swallow study. For example, if a patient has a vocal fold paralysis resulting in glottic incompetency, barium and other consistencies are presented in measured amounts using a syringe. For this patient, material was administered in a more “real life” setting. As we entered the room, a giant x-ray machine, in which the patient was placed, sat dead center. An observation window with computers and data recorders was off to the side. We all had to wear thick, heavy smock-like aprons filled with lead that covered our thorax and thyroid areas, to protect us from the x-rays. I felt silly wearing such a heavy cover, but excited at the same time to be able to fit in with the other professionals in the room.

Mr. Haxer gave the patient some barium coated food samples along with liquids. He then requested that she hold them in her mouth until cued, and then swallow. Additionally, she was asked to puff out her cheeks in order to distend the pharynx. He first used liquid barium in the anteroposterior (AP) view, and then in a lateral view. Then he had her normally swallow peaches and cookies, mixed in with the barium, and repeat an /i/ sound as we all watched on the large, elevated computer screen. I could see the epiglottis fold over the larynx as she swallowed along with residue of the barium, seen black on the x-ray, as it was chewed and swallowed. Although there wasn't any sign of anything collecting in a pocket, it is not respectable to tell a patient that they are not feeling what they're feeling. There may have been evidence of a premature spill, but with a functional swallow, her sensations may simply be from the slow healing process of the tonsillectomy.

Although I was extremely excited to sit in on the three-phase, I think the patients that

were most interesting were the three who had each undergone a laryngectomy. A laryngectomy is the full removal of the “voice box” or larynx, resulting in post-operative respiration through a surgically-created opening in the neck called a stoma. Each of the patients had a stoma and had an alternative way of speaking, since they had no vocal folds to vibrate and create sound. One used a ‘hands-free’ speaking valve placed on the exterior wall of the stoma, while the others had an electrolarynx, which is a battery operated device allowing for vibration, placed inside the oral cavity. As the mouth moves, the vibratory signals from the device are shaped to create sound. Each of these devices makes the speaker’s voice sound ‘gurgled’ and/or robotic.

During the laryngectomy operation, a channel (tracheoesophageal tract) is made through the wall between the trachea and the esophagus. A voice prosthesis (one-way valve) is inserted into the tract. Two of the three patients had come in as ‘emergency’ appointments due to leakage through their prosthesis. Using latex gloves, Mr. Haxer took off the strap on the first patient’s neck and carefully pulled out the Lary tube (used to maintain stomal patency) and old prosthesis to replace the latter with a new voice prosthesis.

When getting radiation after surgery, as these patients were, the effects are cumulative. This means the effects of each previous radiation treatment will be present and accumulate with the next treatment. This can cause the tissue around the operated area to swell, which was evident in the patients. Mr. Haxer used his thumb to cover the stoma and asked the patient to say “ah,” count to ten and announce where he was from to listen and feel for degree of vibration of the esophagus. The man, as with each of the others, had a gurgling quality to his voice.

As I watched Mr. Haxer work, I was able to see a lot of the mucus leakage and bleeding because of the loose prosthesis. He used a sizing tool to measure the width of the tracheoesophageal (TE) wall. The placement of the tool caused some irritation of the tract

which caused the patient to cough heavily and expectorate more mucus. This was definitely not the most attractive sight, as I'm sure you could imagine. Mr. Haxer used a 'dummy Tylenol' gel cap to aid in the insertion of a downsized prosthetic. He then placed the probe inside the tracheoesophageal tract and asked the patient to slowly drink from a water glass as the capsule dissolved. The insertion of the tubes seemed very uncomfortable for the older gentleman. He looked to be in a lot of pain as Mr. Haxer literally went in through the TE wall with the probe, causing extreme amounts of phlegm and coughing episodes. It looked and sounded like he was suffocating as the man became teary eyed and tense. Mr. Haxer kept telling him to "just breathe."

Following placement of the prosthesis, the patient was told to drink his ensure as we watched the swallow to make sure it didn't leak around or through the newly fit prosthetic. Mr. Haxer cleaned out excess fluids and secured his new voice prosthesis tube with a length of fishing wire to keep it in place. I felt so bad for the older man as he sat in the chair with me staring at his neck and Mr. Haxer trying to clean inside his throat. The mucus and other secretions were indeed pretty gruesome, but as I watched this whole procedure with the man's family in the background, I kept thinking about all the work they must have to go through on a daily basis to keep their loved one functioning in an optimal way. It made me realize how much time and effort needs to be put in to take care of someone with a laryngectomy. The family, as well as the patient, has to learn and become familiar with a new lifestyle along with detailed and time consuming procedures necessary for optimum maintenance of the voice prosthesis.

The procedure for the other two patients that underwent a laryngectomy was relatively the same. With the second one, Mr. Haxer was worried about the prosthesis dislodging because it was "seated wrong" in the TE tract. He used a 16 French duckbill style prosthesis, which

correlates with the width of the tract, and a #8 French catheter instead of the tracheal retention collar. He was what's known as a "non-speaker," in which his body does not want to make sound, causing him lots of discomfort and chest pain when he speaks.

I liked the final laryngectomy patient the best. His prosthetic was more inclined, so it was easier for secretions to travel towards the opening, but his stoma seemed less irritated. He and his wife also seemed like a very entertaining couple. The husband was very funny and made faces to me as the wife had her hands positioned around his neck. His wife said he usually tells people that "my nose is an ornament....I use my neck to breath," since patients with stomas cannot inhale through their nasal cavity. He also wore a 'neck breather bracelet' that helps notify others that he has a communication disability. I thought this was very interesting because I know how some people can get frustrated or nervous when they come in contact with someone who can't speak the same way they can.

The procedure for this man was much easier than the other two patients and the wife finished up by applying a silicone based adhesive, pressing tightly with a tongue depressor to lock out any air bubbles, to cover the hand-free speaking device over the stoma. I could hear the man as he breathed heavily through the device and it reminded me of breathing through a snorkel like we do at swim practice. It was very airy and created the gremlin-like voice when he spoke.

Another patient that was waiting in the hall for us to consult was a young man with a tracheoesophageal fistula that coincided with bilateral adductor vocal fold paralysis. He also had additional medical issues of aspiration, bronchitis, and pneumonia. He had no sensation below his vocal folds and had used lots of effort to speak at only a soft level. His voice was breathy and only came out as a whisper. When the vocal folds cannot move (are paralyzed), the body can recruit the muscles above the vocal folds, also known as the 'false' vocal folds, to make

sound. This means that his vocal folds are trying to close from front to back instead of from side to side. Mr. Haxer informed the patient, as well as me, that if this behavior continues, it will become habitual for the patient.

During therapy, the patient was able to produce an /i/ sound in a high-pitched voice, proving that the 'true' vocal folds are making some sort of contact. It is important not to force the vocal folds to produce sounds, such as with this patient, even if some progress has been made. Mr. Haxer recommended that the patient practice more of a soft stage whisper when speaking instead of the rough whisper that he was using.

Probably one of the youngest patients that I saw with Mr. Haxer was a little girl that has a laryngeal disorder where her throat sporadically closes up when she breathes. During normal respiration, the vocal folds abduct, or open, to allow air to flow into the trachea. As we exhale, the vocal folds adduct, or close, to produce sound. Especially while running, this patient experiences a tense closure of her vocal folds while breathing in. The vocal folds normally adduct during sneezing, coughing, etc, but should not cause such a tense closure during inhalation. If left untreated, this can possibly lead to serious respiratory problems in the future for this patient. In order to prevent future hyperventilation, patients with respiration difficulties such as this, need to learn to train their body to think about breathing and modify their inhalations and exhalations by taking in two sniffs of air nasally and releasing the air out of the mouth through pursed lips. Mr. Haxer had the client practice this modified breathing technique by walking slowly with her up and down the hallway.

It is most natural that this patient would have more difficulty with her breathing during times of physical activity. Mr. Haxer has had many athletes, including national swimmers, who have had similar problems where breath modification was critical while practicing (even in the

pool). Being a swimmer myself, Mr. Haxer related the strategies and repetitive practice to my breathing techniques in the water. Since the patient was a runner, he suggested slower running and practicing the modified breathing during the straight-aways of the track and using her regular breathing when running around the curves.

The next woman to come in was an older lady who was diagnosed with Parkinson's disease. Parkinson's disease is "a degenerative disorder of the central nervous system that often impairs the sufferer's motor skills and speech" ("Parkinson's Disease," 1). It can cause an increased effort for speaking and soft voice, as seen with this patient. Like Haxer stated earlier, the body tends to habituate compensatory behaviors even if those behaviors are less than optimal. Thus, it is important to teach or train your body to use specific techniques needed to improve voice quality. Together they practiced taking in deep breaths and holding an "ah" sound for as loud and long as possible.

The goal for this patient was to keep loudness and quality constant and to be able to notice that change versus when she normally speaks. To work on pitch, they began at a comfortable high and low and then gradually tried to increase the loudness of voice at those pitches. Using an activity book, she practiced shouting out listed words and phrases when modeled by Mr. Haxer. Going from simple to more complex activities, she loudly pronounced the written words to the upper corner of the room. To make this louder voice habitual, she needed to work on these phrases, as well as her functional sentences, and start becoming aware of the intensity of her voice. She was assigned activities from the book and told to tape record and listen to her own voice as she spoke.

Next, we had an acid reflux patient. This lady had experienced ongoing irritation and discoloration of the larynx, and many months of trying to get her thickened laryngeal/pharyngeal

secretions under control. Usually with acid reflux patients, the stomach turns on its “acid pumps” whenever anything enters the stomach. This can include food, water, or even mucus that may be swallowed when being sick, causing stomach aches and pains.

Most acid reflex patients may be prescribed a proton pump inhibitor, such as Prilosec, to shut down the number of acid pumps in the stomach. Eating routines, however, can also lead to problems with the stomach acid. Caffeine, for example, is a key agent of relaxing the lower esophageal sphincter, which can increase the risk of acid regurgitation into the larynx/pharynx. Decreasing the amount of caffeine intake, along with spicy and citrus foods, may be crucial depending on the severity of the disorder. For this particular patient, the behavior that was needed to be altered was the timing of late night suppers. Mr. Haxer recommended that she try to eat earlier in the evening so that her stomach acid pumps were not active while she slept. For her vocal difficulties, vocal function exercises were also advised as tasks to recoordinate the vocal subsystems.

The following patient came into the room with a small red straw in her mouth. I smiled at her as she walked in and sat, but didn't fully understand the relevance of the straw until she told me about why she was seeing Mr. Haxer. She had experienced bronchiolar pneumonia, internal blood clotting difficulties, and continued symptoms of a chronic cough. She coughed numerous times in the room while she was talking and used her straw to help make the air go in slower during inhalations. The patient claimed that the mucus felt “like hand cream on the pharyngeal wall.” Mr. Haxer seemed to stress a proactive stance to solving this problem, which should especially be used during times when the patient was socially involved with her friends. He explained to me that when the patient begins to feel the ‘tickle’ in her throat coming on, it should be a cue to politely step out of the conversation and try to go into her swallow exercises.

Because the airway is the trigger to the cough, the swallow helps to “reposture” the larynx by substituting one laryngeal closure (the swallow) for the abrupt adductory closure of the vocal folds that was due to the cough. A slow or over exaggerated swallow allows the vocal folds to gently close from bottom to top and open back up to intervene with the body’s “misbehaving larynx.” Drinking water seemed to also help with the coughing episodes, but doing a quick dry swallow before sipping the water was most beneficial. Using the straw to control her breathing also helps manipulate the air pressure and to stretch and relax the extrinsic suprahyoid laryngeal muscles.

The final patient of the day was another one that I had seen previously. He was a Tumor, Node, Metastases (TNM) patient suffering from T4 Carcinoma with a large tumor around his lymph nodes. He had undergone intense chemotherapy with dual radiation treatment that affected his entire body, resulting in hair loss and a decrease in taste preferences. He was a little hard to understand with his nasal voice, but the dubhoff feeding tube that ran around the back of his head and up his nose didn’t seem to aid in a clear voice.

As a clinician, it is important to be updated on your patients’ condition, whether directly from your patients, other doctors, or therapeutic reports and dictations. Almost immediately after entering the therapy room, Mr. Haxer and I received news that the cancer had recently spread to other parts of his body and was said to be terminal. My pen stopped writing as I heard the awful news and I know that Mr. Haxer felt great remorse for his patient. They talked for a while about the condition and did a few of his supraglottic swallowing exercises. He had been working on a voluntary breath hold maneuver to help with the effortful swallow.

As the day finally came to an end, I felt a small burst of relief pass over me. I had been really excited to do this shadowing experience and had enjoyed spending the day at the hospital,

but it definitely was a tiring voyage. Both Mr. Haxer and I had observed patients from 8 in the morning until almost 5 pm with no lunch break and only a few sporadic moments for patient updates and dictation. He had serviced nearly twelve patients, two of which were emergency visits, throughout the day. I could have sworn that his pager went off about two dozen times over the course of my stay. It seemed like everyone needed an opinion, a question, or an appointment with Marc Haxer. At times, the interruptions and the ‘running around’ reminded me of my own life. I kept thinking, maybe this profession is just perfect for me.

I have had many different observational experiences over my past couple years being in the Special Education department, but none quite like this one. It was definitely one of the best educational experiences for me and sort of liberating to be able to get out and see some real patients suffering from the types of disorders that we have learned about in class.

As with any other kind of medical treatment, a formal evaluation may first be conducted to establish the status and possible therapeutic approaches for each patient. Mr. Haxer did this with each of his patients, either during my visit or in previous sessions. “The primary objectives for performing a voice evaluation are to discover the etiologic factors,” or causes, that are “associated with the development of the voice problem and to describe deviant vocal symptoms” (Stemple, 149). The first component of the diagnostic evaluation is the medical examination. This can include a complete oral-facial examination, viewing the functions of the muscles and cartilages of the head and neck areas, and endoscopy of the larynx, along with other possible analyses such as radiation, blood, and swallow studies.

Interviewing the patient, which is a second component, can be conducted in different styles. Most of the information from this part of the voice evaluation consists of medical, social, and developmental history of the patient and the patient’s perspective of their disorder and how it

may impact their lives.

The clinician's perceptual evaluation of the voice is one of the most important components. What they can hear in their client's voice may be different from what that patient, or any other Speech-Language Pathologist, hears. This was evident with the tumor patient who had his lymph nodes removed, for example. The clinician typically examines the quality of respiration, phonation, resonance, pitch, loudness, and rate in order to detect the problem and develop a therapeutic plan. Other parts of the evaluation include the instrumental analysis, both acoustic and aerodynamic, and the functional evaluation of vocal fold movement.

Therapy approaches for almost every patient are overlapping. Depending on the problem, there are numerous vocal fold exercises and facilitating techniques that can be used to strengthen the weaker areas and increase therapeutic progress. While learning about these in recent class sessions, I reflected back on my observations at the hospital. As Mr. Haxer was teaching the lessons on the therapies for different conditions, I felt like it was a review from the lessons he taught me during my shadowing. For example, the pitch gliding exercises, used to stretch and relax the vocal folds, and the breathing exercises of two sniffs and an oral exhale (for transition from treatment), are a couple that I had seen during therapy sessions at the hospital. However the treatment is conducted, the main therapeutic goal for any patient is to change the habitual pattern in the voice production of a disordered voice.

One thing Mr. Haxer strongly emphasizes in class is the extreme importance of hydration. He advises that when consulting any patient with voice problems or abnormalities, you should tell your patients to drink at least one-half the amount of their body weight in ounces of water. Drinking water helps to hydrate the vocal folds, making the mucus "wet," and thus can improve voice quality. Other ways to hydrate your throat are sucking on hard candy and eating

large amounts of “wet snacks.” Wet snacks are fruits and vegetables that have high pulp and water contents, such as cucumbers, carrots, peaches, apples, and many others. Sometimes the timing of eating, along with avoiding certain foods (ie: highly acidic), must also be adjusted in the patient’s schedule, just like mentioned earlier with the acid reflux patient.

When watching Mr. Haxer, I was reminded of certain lessons that have been imbedded into me by other professors at Eastern Michigan University. The courses I have taken in the program’s Special Education department have given me a fundamental awareness of the different types of disorders that can affect voice and speech. As a clinical Speech-Language Pathologist, it is important to have a basic knowledge on a variety of disorders because you will be working with a variety of patients. Each patient, even if they have the exact same diagnosis as another patient however, is different. We have learned in a majority of speech classes that, as a clinician, you will never have two patients that are the same. On the same hand, it is important to show care and respect for each client and use your knowledge and experience to aid in the progress of the client to the best of your abilities.

Along with lessons from Mr. Haxer’s class, teachings in other classes have tied into the clinical practices that were seen during my observation. In Clinical Methods with Professor Cupples, I have learned about the professional ethics that a Speech-Language Pathologist has to maintain in order to practice. Following the American Speech-Language and Hearing Association (ASHA) Code of Ethics and Scope of Practice is critical for conducting therapy in any setting. Some of the rules that are described include protecting client confidentiality, acceptance of diverse patients, and practicing in a way that you are certified to do as a professional depending on levels of education, experience, skill, and proficiency. Treatment sessions must be done in a hierarchy where clients begin working on tasks that are less difficult

for them and gradually move upward to more complex activities. This was seen in my observations at the hospital with every patient. Logs of the clients' activities and progress must also be recorded for documentation. Mr. Haxer did this as he made oral dictations over the telephone after each client's session.

As I watched Mr. Haxer, I could see those specific qualities that make him into an ethical clinician. He shows great concern and care for each of his patients. In return, it was noticeable that each of his patients showed a great amount of trust and respect for him as their clinician. This ties in with client confidentiality. Building trust with the patient allows you as a clinician to be more approachable, accountable, and respected as a professional. I have been able to observe other clinical settings, but the interactions I saw between Mr. Haxer and his patients were some of the best I had ever seen. He seems to get involved with the lives of his clients and knows numerous details about each of them, even if he hasn't seen them in months. Watching him converse made me think of the type of relationship I want to have with my clients when I become a clinician. He used humor and his knowledge of different cultures, geography, entertainment, etc. to make that connection with each patient, no matter what their age.

Having good relationships with patients, as stated in Dr. Cupples' class, is one of the most important characteristics to becoming a good clinician. It also helps to create a better prognosis because it makes patients feel more comfortable and motivated to work on improving their disabilities. As I sat and watched the different sessions, I could really see how much Mr. Haxer cares for his patients. He described a vast amount of them as his "favorite" patient and almost every one of them expressed their positive and comfortable feelings towards his therapeutic abilities.

Good clinicians have other characteristics, such as being positive, honest, polite, and

assertive. It is also important, however, for a clinician to be emotionally stable. As the patient's clinician, it is ethical for you to have empathy over your patients' conditions, but some things may occur in therapy that you may not expect. For example, it is hard to hear when one of your cancer patients, like in Mr. Haxer's situation, reveals that they found out their cancer has spread and would be terminal. Every clinician has outstanding sessions where a lot of progress is made and goals fully accomplished, but there will also be some disappointing and less progressive sessions as well. Sometimes it will be extremely difficult emotionally, but as Speech-Language Pathologists, it is our job to try to do everything we can to assist in creating a functional and optimal quality of life for each individual patient we encounter. All we can do is try our best with the amount of time we have with them and hope for the better. Not every patient will be perfect or easy to treat, but in our profession, we hope to make a significant difference in each life we touch.

The experience of shadowing a clinical Speech-Language Pathologist was more than anything. I got to walk a day in the shoes of clinician Marc Haxer. My visit to the University of Michigan Hospital was much different from any of the other observations I have made over the years. Although it was a little intense for me as an undergraduate student, I felt like I gained a lot from shadowing Mr. Haxer. I was amazed with some of the quick thoughts, responses, and procedures that he used with his patients. He made everything look so easy. I guess that the more practice and more experience you have, the greater the comfort and confidence will be in what you are doing. With the variety of appointments I got to 'sit in on,' I learned how hectic, stressful, fun, and thrilling an average day at the hospital can be.

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