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RESEARCH REPORT

‘I don’t really know where I stand because I don’t know if I took something away from her’: Moral injury in South African speech–language therapists and audiologists due to patient death and dying

Nabeelah Nagdee | **Victor Manuel de Andrade**

Department of Speech-Pathology and Audiology, University of the Witwatersrand, Johannesburg, South Africa

Correspondence
Nabeelah Nagdee, Department of Speech-Pathology and Audiology, University of the Witwatersrand, Johannesburg, South Africa.
Email: nabeelah.nagdee@wits.ac.za

Abstract

Background: Speech–language therapists and audiologists (SLT&As) may encounter difficulties when confronted with patient death and dying, which may conflict with their moral beliefs and result in moral injury. Furthermore, South African SLT&As practice in a country with a high mortality rate, which may add to the complexity of their experience. Moreover, they may be influenced by African philosophies promoting care, which might conflict with their experiences of patient death and dying.

Aims: To explore the moral injury experienced by South African SLT&As in patient death and dying, and how they overcame the injury.

Methods & Procedures: This article forms part of a larger qualitative study that explored SLT&As’ experiences of patient death and dying in South Africa. Thematic analysis was conducted on the transcripts of 25 episodic narrative interviews conducted with South African SLT&As on their experiences of patient death and dying.

Outcomes & Results: Findings suggest that South African SLT&As experienced helplessness, guilt and anger in patient death and dying. However, with support from the allied team, engaging in self-reflection and religious practices, they reported alleviation of moral injury.

Conclusions & Implications: In order to mitigate moral injury in South African SLT&As, they require professional education, self-care strategies, guidelines and support from the teams in which they work and their supervisors. Research is needed that explores how SLT&As’ biographical characteristics and interactions with significant others of dying and deceased patients, may result in moral injury.

KEYWORDS
moral injury, patient death and dying, speech–language therapists and audiologists

What this paper adds?

What is already known on this subject?

- Moral injury and measures used to overcome the injury have been explored in military personnel, doctors and nurses, but not in SLT&As. However, studies that explored the perceptions of SLTs and/or audiologists regarding providing palliative care and of death and dying, particularly that by Rivers et al. in 2009, suggested that these professionals may be at risk of experiencing emotional trauma due to patient death, particularly when not receiving undergraduate education on this subject. However, the extent of this trauma and the support needed to overcome it is unknown because the participants in these studies may have not experienced patient death, and were only students or just SLTs.

What this article adds?

- This article highlights the complexity of speech–language therapy and audiology practice when confronted with patient death and dying. South African SLT&As may have to make decisions that conflict with their morals and professional practice standards, especially as the helping nature of their profession is characterized by African philosophies that promote care, which may result in moral injury.

Clinical implications of this article

- This article indicates that in addition to undergraduate education on patient death and dying, SLTs and audiologists require continuous professional education on this topic, self-care strategies, support from the teams in which they work, and their supervisors and guidelines for when they encounter patient death and dying.

INTRODUCTION

Speech–language therapists and audiologists (SLT&As) may encounter complex ethical dilemmas in their practice, particularly when managing terminally-ill patients (American–Speech–Language–Hearing Association (ASHA), 2009). The complexity of these dilemmas may increase when there is conflict between their morals and professional practice standards, such as ethics (Brahmbhatt, 2016). This conflict may lead to moral injury (Molendijk et al., 2018).

Moral injury was originally defined as the violation of 'what is right in a high-stakes situation' (Shay, 2014: 37). However, the definition has recently evolved into acting or witnessing acts that lead to moral transgression, which has lasting negative effects on one's psycho-emotional, social, behavioural and spiritual well-being (Barnes et al., 2019; Litz et al., 2009).

Rivers et al. (2009) concluded that student SLT&As may be at risk of developing emotional trauma and experiencing professional hurdles in patient death and dying, especially if they do not receive education on this topic in their undergraduate programme. Wojan (2006), who explored qualified SLTs' encounters with patient death, reinforced Rivers et al.'s (2009) conclusions. She found that these professionals' encounters were characterized by detachment, depersonalization, sense of inadequacy, anger, decrease in work performance, sadness, frustration, depression and anxiety (Wojan, 2006). It has been proposed that all these feelings may be related effects of moral

injury (Williamson et al., 2018; Barnes et al., 2019). Additionally, one of Wojan's (2006) sub-aims was to obtain insights into SLTs' emotional and physical responses to the deaths of paediatric and adult patients. However, she reported that the age of the patient did not seem to influence professionals' responses to patient death, but she concluded that SLTs experienced more deaths of adult patients than paediatric patients (Wojan, 2006).

Research regarding SLTs' experiences of death has mostly explored this experience in the context of adult palliative care. This research has revealed that SLTs encounter emotional conflict when providing speech–language therapy-related palliative care services. They are required to prepare patients' and patients' significant others for the end of life, which contends with the traditional models of speech–language therapy practice that promote progress (Hawksley et al., 2017; Crumrine, 2020). This conflict may lead to SLTs who provide palliative care services to adults experiencing moral injury.

In order to prevent and overcome the injurious effects of moral injury in their practice, SLT&As need to use self-care strategies to maintain their well-being, so that they can optimally care for patients (Hossain & Clatty, 2020). Additionally, the American Psychiatric Association (APA) (2020) has advised that healthcare professionals (HCPs), such as SLT&As, receive organizational and social support. These support services may be provided through employee wellness programmes and by colleagues and supervisors. Employee wellness programmes should encourage and provide HCPs with the opportunity to discuss their stressors (APA, 2020). Furthermore, SLT&As' supervisors should encourage the fostering of supportive relationships among their teams and also allow for their teams to have open discussions regarding ethical decision-making (APA, 2020; Greenbergh et al., 2020).

However, topics on making difficult ethical decisions should also feature in educational programmes (APA, 2020). Additionally, it has been suggested that to promote holistic and patient-centred care, educational programmes could include an appreciation and understanding of religion and spirituality in speech–language therapy practice (Mathisen et al., 2015). This holistic and patient-centred care may improve patients' and their significant others' well-being, and may ensure that SLT&As uphold bioethical principles when providing services to patients (Mathisen et al., 2015). By aiming to improve patients' and their significant others' well-being outcomes and upholding bioethical principles in practice, it may reassure SLT&As that they have provided the best possible care to patients when patients die. This reassurance, ultimately, may mitigate the moral injurious effects that SLT&As may experience during instances of patient death and dying.

In Australia, the healthcare professional education programmes of HCPs, such as those for SLT&As who may form part of the palliative care team, have collaboratively developed the Palliative Care Curriculum for Undergraduates (PCC4U) project (Mathisen et al., 2011; Palliative Care Curriculum for Undergraduates (PCC4U), 2006). This project aimed to promote 'palliative thinking' (Mathisen et al., 2011: 274) among HCP students, including speech–language therapy students, who, when qualified, may form part of the palliative care team. Speech–language pathology students who participated in the pilot PPC4U project were afforded opportunities to discuss life-limiting illnesses, death and dying, and the associated grief that they have experienced in their personal life and clinical experiences (Mathisen et al., 2011). Discussing these topics may mitigate the effects of moral injury, such as anxiety (Mooney, 2005); additionally, when speech–language therapy students participated in the pilot PPC4U project, they reported increased knowledge and confidence in approaching patient death and dying (Mathisen et al., 2011).

It is reported that South Africa has one of the highest mortality rates in the world. This high mortality rate may be due to multiple-burden of diseases, violence and motor vehicle accidents, amongst others (Central Intelligence Agency (CIA), 2014; Ferrante, 2014; Statistics South Africa (STATS SA), 2017; World Health Organization (WHO), 2016; Radebe, 2014; Writer, 2015). Furthermore, in South Africa, historically SLT&As practiced in the speech–language therapy and audiology profession. However, now graduates qualify and practice as either SLTs or audiologists. In the South African context, these professionals may adopt African philosophies and principles, such as the Ubuntu philosophy and Batho Pele principles. The Ubuntu philosophy refers to individuals' humanness (Tutu, 2004), and the Batho Pele principles are based on putting people first (DPSA, 1997). These principles include service standards, openness and transparency. These philosophies and principles may influence SLT&As' moral injury in the South African context. Therefore, considering the dearth of literature on this topic in South Africa, it appeared necessary to explore SLT&As' moral injury associated with patient death and dying.

This article is drawn from a larger study that aimed to explore South African SLT&As' experiences regarding patient death and dying. However, it describes the moral injury that may arise from patient death and dying among SLT&As in South Africa and how they may combat these injurious effects.

METHOD

Research design

A qualitative narrative research design was employed to address the aims of the study from which this article is written. In-depth interviews were conducted with the SLT&As who volunteered to participate in the study. This research design and data collection technique allowed for the authors to delve in-depth into trying to understand SLT&As' experiences with patient death and dying and their perceptions of these phenomena (Rejnö et al., 2014; Minichiello et al., 2008).

Participant

Professionals registered as SLTs and audiologists were invited to participate in the study. These professionals were recruited through maximum variation sampling, as the first author (N.N.) wanted to obtain varying perspectives and experiences regarding patient death and dying. Professional associations with which SLT&As are registered agreed to disseminate participant information sheets to their members inviting them to participate in this study. Additionally, snowball sampling was employed by participants informing other SLT&As of the study and asking others to consider participation, as per the first author's request (Profetto-McGrath et al., 2008; Pitney & Parker, 2009; MacNee & McCabe, 2008). A total of 25 SLT&As consented to participate in the study. All were female, from diverse religious and cultural backgrounds, of various ages and had differing years of experience which ranged from 2 months to 40 years. They practiced at different types of institutions, such as schools, public and private, and/or healthcare institutions, frail care centres and/or academia. This study aimed to provide insight into SLT&As' experiences regarding patient death and dying, and did not set out to describe their experiences based on their biographical characteristics.

Procedure

Once ethical clearance was obtained from the University of the Witwatersrand's Human Research Ethics Committee (non-medical), a pilot study was conducted by the first author to pre-test the research tools (Creswell, 2009; Grady, 1998), after which the main study was conducted. N.N. conducted audio-recorded in-depth interviews with participants. Conducting in-depth interviews with open-ended questions allowed the SLT&As to share their unique and personal experiences regarding patient death and dying (Minichiello et al., 2008). N.N. used an interview guide (see the Appendix) to aid her in giving rise to discussions about participants' experiences with patient death and dying. When creating the interview guide, N.N. used the questionnaire formulated by Rivers et al. (2009) in addition to literature that explored and described HCPs' perceptions with patient death and dying as references. The topics discussed in the interview were participants' biographical information, experiences with patient death and dying, and coping with patient death and dying. Since the topics discussed during the interview could have resulted in distress in participants, participants were provided with a distress protocol at the beginning of the interview. This provision aimed to guide participants in working through their distress. However, none of the participants reported needing to employ the distress protocol. A total of 17 interviews were conducted over Skype, while eight face-to-face interviews were conducted. The interviews were transcribed and the analysed transcriptions were emailed to participants for them to review for member checking.

Data analyses

The findings of the study were analysed using the six-step approach to thematic analysis recommended by Braun and Clarke (2006). N.N. first familiarized herself with the data by writing and typing participants' transcriptions. Thereafter, the authors generated codes inductively and deductively. They created a code manual that included definitions and examples of text to explain each code. This manual was particularly useful to N.N., as it guided her in applying the codes to the transcript (Nowell et al., 2017; Joffe & Yardley, 2003). The authors engaged in peer debriefing on a biweekly basis. They reflected on and documented in a journal how their thoughts and ideas were evolving as they engaged with the transcriptions (Nowell et al., 2017). They also updated the coding manual when necessary. The approach to coding that the authors employed is in line with the trustworthiness criteria proposed by Lincoln and Guba (1985), and will further be discussed in the trustworthiness section of this article.

For the purpose of this article, some of the codes that were inductively generated indicated how patient death and dying may have resulted in the SLT&As experiencing moral injury and the coping mechanism that they used to overcome it. Examples of these codes are indicated in Table 1. The authors expanded the codes into themes. The themes on moral injury caused by patient death and dying and the coping mechanisms that aided them in mitigating moral injury are presented in this article. Once the themes were identified, the authors reviewed the themes to ensure

TABLE 1 Examples of coding

Interview excerpts	Coding
He said that he had put in the NGT but when we went to see the patient there wasn't an NGT inserted. We had spoken to the nurses and they said he never put in a NGT. … Myself and the physiotherapist said to him, 'We think that you inserted it incorrectly, we think that it is in the lungs.' He said, 'I'm the doctor, you're not qualified. You insisted on having this, you will feed the patient now.' We said, 'We think it's in incorrectly,' and he said, 'No, this is my medical call it's in correctly, you will feed the patient.' Myself and the physiotherapist did not feel comfortable to do it and the nurses fed the patient. The patient passed away because the patient aspirated on his food.	Deceived Undervalued
[S]peaking out loud, going through the situation and frequently discussing it; even if it was just out loud to myself. Just by hearing and processing it helped me. It's important to verbalise it than to just keep it in.	Self-talk Self-reflection

that the themes were representative of the data obtained, which they were.

Trustworthiness

To ensure credibility during the data analysis process, two researchers analysed transcriptions and created a code manual to guide them in the analysis (Lincoln & Guba, 1985; Crabtree & Miller, 1999). The analysed transcriptions were emailed to participants for them to review for member checking. Employing the member checking technique allowed the participants to verify if the authors analysed their experiences accurately. This also enhanced the credibility of the study and the conformability of findings by mitigating for bias (Olivia, 2016). Only one of the participants amended her transcription, which was thereafter re-analysed. This re-analysed transcription was re-sent to the participant for review, after which she approved the transcription.

The researchers also engaged in peer debriefing when analysing the transcriptions, which also enhanced the study's credibility (Lincoln & Guba, 1985). The discussions during these meetings were also noted. These meeting notes formed part of the audit trail. The audit trail also included raw data (consent forms and audio recordings), data reduction, analyses, reconstruction and syntheses facets (interview transcriptions), feedback received from the member checking review, tabulations of codes (extracts) and themes extracted from these codes and instrument development information (feedback received from the participant who participated in the pilot study), all of which was stored on a password-protected computer. Creating an audit trail ensured dependability of the study, so that other researchers who may want to replicate this study are able to (Pitney & Parker, 2009).

RESULTS

The results highlight the moral injury in participant SLT&As and the coping mechanisms that aided and could have aided them in overcoming moral injury.

Moral injury experienced by the SLT&As due to patient death and dying

As per Table 2, SLT&As experienced moral injury due to patient death and dying. It seems as though the SLT&As experienced helplessness when their patients died, as they were not able to help these patients. They were also overcome by guilt, particularly when their patients died, because they wondered if they were also bound by the standards of speech–language therapy and audiology practice. The SLT&As were angered by how doctors, nurses and religious leaders approached and viewed terminally-ill patients. They were also angry at a Higher Power in instances of patient death to the extent that they questioned the Higher Power about why these instances occurred.

Coping mechanisms employed and suggested by SLT&As to overcome moral injury when they experienced patient death and dying.

In order to overcome moral injury associated with their experiences of patient death and dying, SLT&As employed a variety of coping mechanisms (Table 3). Coping mechanisms employed by SLT&As to overcome these effects included engaging in religious practices and employing self-reflection. Furthermore, working within a team also seemed to provide support to participants when they experienced patient death and dying, as the SLT&As were able to discuss these patients with their team members. However, the SLT&As would have also appreciated support from their supervisors and guidelines on making

TABLE 2 Moral injury in the SLT&As due to patient death and dying

Presentations of moral injury	Interview excerpts (P = participant)
Helplessness	I think the fact that she was still pregnant—it wasn't just the person dying but also the child dying. There wasn't anything that I could do for them. She was declared brain-dead and the machines were turned off. (P2)
	I think in this case there was utter helplessness. There was nothing anyone could do and it is really cheesy to say, everyone says this, 'I come into the profession because I want to help people'—but we do. When we can't fix it, we can't help someone—we feel terrible. (P6)
Guilt	One day, I went into her room and she had stuffed a lot of tissues into her mouth and it must have taken her ages to do, as it was very difficult for her to move. She had packed her mouth full of tissues and was struggling to breathe. I had rushed in and taken all the tissues out of her mouth. … It was only after everything had kind of calmed down and we had some time to settle it, I realized that she was trying to kill herself because she just didn't want to live anymore. I felt so guilty for taking that away from her. It's something that I think quite a lot about, because in that situation the right answer is to go and help her and remove the tissues from her mouth, but ethically speaking I don't really know where I stand because I don't know if I took something away from her. (P1)
	I think that feeling of guilt—if I did more and was in touch with him as well as if I was less worried and had crossed that professional boundary and been more for available for more of a friendship relationship, would it have made a difference. … Perhaps, I was being selfish wanting to remain within my professional boundaries. Was it a selfish decision on my part, and should I have done more for him as a person and not at a more therapeutic level? (P9)
	When I heard the news, I felt this incredible guilt because the patient had died from malnutrition and in the end the patient started to resent me because I told him what he could and couldn't eat and he would fight with me. I had this mind-set that I was the speech therapist and I knew best. All the patient wanted was a McDonald's burger and I wouldn't allow him to have the burger…I went to the ward in the afternoon and his sister was there. The minute I saw her I hugged her and cried. I said, 'I'm sorry. This is my fault' and that is all I kept saying' (P16)
Anger	I think that the doctors and nurses had the mentality that if the patient was end-stage HIV and had all these comorbidities; they would leave the patient to die. I sort of fought just to say well it's inhumane to let him or her just die like that. (P4)
	I feel quite strongly that the outcome was affected by the young doctor on duty because he rushed around and gave the patient adrenaline and she was put on antibiotics. … I actually felt quite angry that she was treated aggressively with antibiotics, when perhaps she could just gone peacefully. (P20)
	The pastor spoke about how this child's life was so fulfilling, but this child couldn't run, she couldn't go to the toilet by herself and she couldn't talk; yet the pastor was saying how her life was fulfilling and now she was fixed. …We thought really that's who she was and that's why we loved her. (P21)
	Sometimes in the moment of feeling emotionally raw you feel like, 'Why would God take a small child away?'(P25)

ethical decisions, particularly when treating terminally-ill patients. They highlighted the need for receiving professional education regarding patient death and dying, and those who received education on this topic found it to be beneficial as it aided them in dealing with patient death and dying.

DISCUSSION

Participants encountered patient death and dying when providing speech–language therapy and audiology-related end-of-life care and when providing routine care to patients. However, the type of care provided did not seem to determine if participants experienced moral injury. The moral injury experienced by participants may be due to them encountering patient death and dying, while trying to uphold their African caring philosophies and principles in their practice as well as the helping nature of their profession. Participants, however, reported employing coping mechanisms to overcome the moral injury. The results included in this paper also have implications in terms of how moral injury may be prevented and for future research.

TABLE 3 Coping mechanisms employed or suggested by SLT&As to overcome their moral injury due to patient death and dying

Coping mechanism	Interview excerpts (P = participant)
Religious practices	I think my religion basically helps me cope better because I think in a way prayer and reading the bible really supports and motivates you, it supports you in remembering that you can't take all the responsibilities and emotional reactions of people … and trusting God with that emotional experience and relaying these experiences to him makes it better for me to cope with it. (P5)
Self-reflection	[I]t's not only important to debrief with other people but I also need to reflect on myself. For instance, I kind of need to have the imagery of myself letting go of the feelings of guilt. (P25)
Support	I did have a supervisor, I didn't feel like she supported me because she would say 'Oh well. Shame, I'm sorry to hear that'. … I kind of was an outsider. I would have liked someone to have shared it with. (P12)
	I would doubt myself, but having that reassurance for the other allieds helped. (P18)
	I think working in a team helps because when something goes wrong and they don't do as well as you thought they were going to do, … where. (P5)
	[W]e question and doubt ourselves—'Did I do something wrong?' or 'What could I have done differently?', the team is extremely supportive. (P20)
Guidelines	With cancer patients something else which should be raised is the ethical practice—when you know that the audiology patient is terminally ill—should you fit the patient or shouldn't you fit with a hearing aid. There are a lot of ethical questions around that … give more professional guidelines on how to cope with it. (P11)
Professional education	I think that at university you should be told that patient death is a possibility and what the necessary steps are to be taken if you encounter patient death. It's important that you deal with your emotions because you can't sweep it under the carpet and you have a right to feel those emotions. You need to work through the emotions because if you don't they will catch up with you and eventually it will bottle over and you're not going to cope. (P13)
	I actually did extra courses and workshops that were offered on death and dying, I think that we did touch a bit on it during our undergraduate training. … I think as part of training all therapists should be expected to attend a workshop like that because it would be really good preparation. (P17)

Patient death and dying results in SLT&As experiencing moral injury

The moral injury experienced by the SLT&As resulted in them experiencing helplessness, guilt and anger.

The SLT&As seemed to have chosen the speech–language therapy and audiology professions to fulfil their need to 'help people' (P6), which may suggest that they adopt the Ubuntu philosophy in their practice. This adoption may aid them in treating patients within the law of duty of care, which is a professional practice standard with which these professionals need to comply (Health Professions Council of South Africa (HPCSA), 2008). Therefore, when their patients were dying, they experienced helplessness and, consequently, guilt.

Once participants' patients died, participants seemed to have been overcome by deontological guilt as they doubted whether they employed the Batho Pele principles in their practice. Deontological guilt as defined by Gangemi and Mancini (2021) is guilt that results from moral transgression. This type of guilt seemed to present as self-doubt in some of the SLT&As. They wondered if practising within the principle of non-maleficence caused them to be paternalistic to the extent that they felt selfish for not considering their patients' autonomy. This paternalism also elicited feelings of altruistic guilt. Altruistic guilt is elicited when individuals realize that they may have caused harm to another individual unjustifiably or when they think that they were selfish towards another individual (Gangemi & Mancini, 2021). Therefore, these feelings of altruistic guilt led to the SLT&As blaming themselves for their patients' deaths. However, in some instances this altruistic guilt caused by paternalism could have been prevented if participants upheld their patients' autonomy. The SLT&As also experienced altruistic guilt marked by self-blame when they realized that being so absorbed in providing therapeutic services and conscious of upholding professional standards when providing these services may have led to their patients' deaths.

The aforementioned findings add to Hawksley et al.'s (2017) research that showed that SLTs who provide palliative care services to adults also experience guilt when these patients die. This guilt is usually due to them not being able to effectively provide the intended quality of life, comfort and closure because they do not have enough time to interact with patients and receive late referrals. SLT&As receiving late referrals from other HCPs has been a source of inter-professional conflict between HCPs and

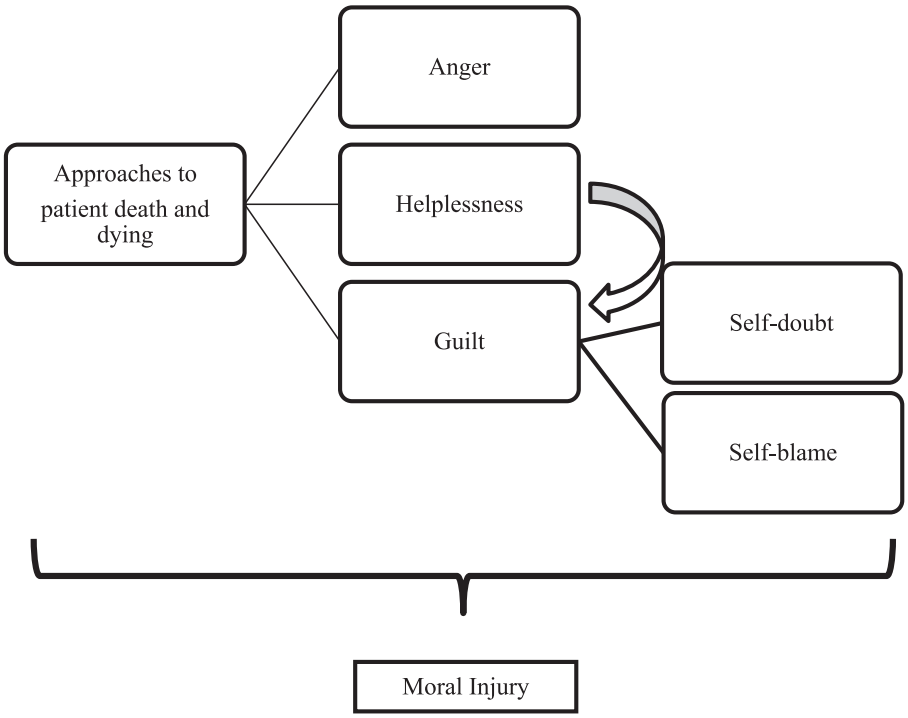

FIGURE 1 Moral injury in speech–language therapists and audiologists (SLT&As) due to the approaches to patient death and dying

SLTs providing palliative care services (Hawksley et al., 2017). Furthermore, from participants whose responses are reflected in this current paper, it seems that they were angry when the doctors and nurses used a different ethical approach to them when treating terminally-ill patients. The SLT&As felt that patients were being harmed by the doctors' and nurses' approach. These sources of interprofessional conflict may be due a limited and unclear understanding of SLTs' role in palliative care (Hawksley et al., 2017; Krikheli, 2020; Crumrine, 2020).

The SLT&As were also angry when religious leaders viewed death simply as a remedy for patients who had disabilities. Participants were angry in these instances, as they felt that patients were being discriminated against. This anger was also directed towards a Higher Power and resulted in the questioning of this Higher Power's ascribed benevolence.

Figure 1 demonstrates the moral injury in the SLT&As caused by the approaches to patient death and dying. The guilt experienced by participants was also caused by helplessness and marked by self-doubt and self-blame.

SLT&As employ various coping mechanisms to overcome the moral injury

In order to overcome the moral injury indicated in Figure 1, the SLT&As employed religious practices and self-reflection, and benefited from support.

Although some participants displayed anger towards a Higher Power and religious leaders, they turned to their own religious beliefs and practices. Their religious beliefs and practices offered them a sense of reassurance that their experiences with patient death and dying were out of their control. This finding builds on Wojan (2006) who found that SLTs who engaged in religious practices received closure from their patients' deaths.

Self-reflection also allowed for the SLT&As to overcome the moral injury associated with patient death and dying. According to Papir-Bernstein (2018), self-reflection is needed in order to achieve self-nurturance. The key components of self-nurturance are self-soothing, shame reduction and self-enhancement behaviours. These behaviours may include reflective practice, and nurture self-esteem in individuals who are emotionally sensitive.

SLT&As benefited from the support they received and their self-esteem was also reaffirmed by working within a team, such as the allied healthcare team. These team members were able to provide esteem support by reassuring participants when the SLT&As displayed reassuring-seeking behaviours and self-doubt. However, the SLT&As would have also preferred supervisory support so that they could share their experiences with their supervisors, especially because it has been reported that discussing moral injury may mitigate the effects of such injury (Williams et al., 2020; Ferrajão & Oliveira, 2016).

Clinical implications

There are several clinical implications that follow from the findings presented in this current article. In order to prevent moral injury in SLT&As, death education should form part of their undergraduate programmes. Continuous professional programmes regarding death should also be offered. These professional education programmes may be structured so as to guide SLT&As on how to make ethical decisions when treating dying patients. These programmes may equip SLT&As with self-care strategies to alleviate moral injury that may result from patient death and dying (Field, 1997; APA, 2020). Additionally, healthcare education programmes of HCPs, such as SLT&As, who form part of the palliative care team, may collaboratively develop palliative care education initiatives similar to the Palliative Care Curriculum for Undergraduates project (PCC4U, 2006). Through this collaboration, there may be opportunities to enhance mutual understanding, reduce inter-professional conflict and promote collaborative practice between HCPs who care for patients who are nearing the end of life. Furthermore, these initiatives may provide SLT&As with an opportunity to discuss their feelings towards patient death and dying (Mathisen et al., 2011). These discussions may prevent or aid in mitigating the moral injury that these professionals experience in instances of patient death and dying.

Additionally, guidelines should be made available to mitigate the uncertainty that is associated when treating dying patients (Kulmala, 2016). SLT&As should also use self-care strategies, such reflective practice, to overcome the distressing effects when experiencing moral injury as advised by Hossain and Clatty (2020). They should be provided with opportunities where they receive support. Additionally, supervisors should allow for information sharing opportunities where their teams can discuss approaches to making complex decisions (APA, 2020; Greenberg et al., 2020) However, not all SLT&As may have these opportunities and some may wish to debrief anonymously. Therefore, professional bodies should provide SLT&As with online social support services, as suggested by White and Dorman (2001), which SLT&As may use to debrief.

Strengths and limitations

Following Rivers et al.'s (2009) study on student SLT&As' perceptions on patient death and dying, the authors conducted a study exploring qualified SLT&As' experiences of patient death and dying. This current article reflects the actual experiences, more than the perceptions, of patient death and dying. It also highlights the associated moral injury. As an extension of Rivers et al.'s questionnaire-based study, conducting interviews with the SLT&As, allowed the present authors to obtain an in-depth understanding of a variety of experiences of patient death and dying, more specifically moral injury. However, a limitation of this current article is that the authors did not explore if SLT&As' interactions with patients' significant others during instances of patient death and dying resulted in moral injury. Therefore, future studies should explore if these interactions during instances of patient death and dying may result in moral injury

Additionally, the study from which this article is drawn did not look at how biographical characteristics may have influenced their experiences with patient death and dying. Thus, other studies on SLT&As' experiences regarding patient death and dying could explore how these characteristics influence these experiences and potential resultant moral injury. The study was also conducted in South Africa. Therefore, it is recommended that similar studies be conducted in other countries to account for contextual variations from those in South Africa. This may provide different insights into SLT&As' experiences regarding patient death and dying. Researchers may also want to explore possible moral injury in other HCPs to account for their scopes of practice. Research on patient death and dying and, in particular, moral injury is needed amidst the COVID-19 pandemic because HCPs may experience more and frequent patient death and dying (Mosheva et al., 2021).

CONCLUSIONS

This paper provides an insight into the moral injury experienced by South African SLT&As as a result of patient death and dying, and recommends ways in which the moral injury may be prevented and overcome. South African SLT&As, when encountering patient death and dying, may experience moral injury when trying to uphold their African caring philosophies and principles in their practice as well as the helping nature of their profession. To mitigate the moral injury incurred, they engaged in religious practices, employed self-care strategies and sought support from other allied health professionals with whom they worked. However, they still expressed the need to receive education and guidelines about approaching and dealing with death and dying and making ethical decisions when providing end-of-life and palliative care to patients. To understand fully the moral injury experienced by HCPs, including SLT&As, related to patient death and dying, more research is needed on how professionals' characteristics, the contexts in which they work and their interactions with significant others of patients who are dying or have died may result in moral injury. This research may also

aid in determining ways in which moral injury caused by patient death and dying may be assuaged.

DATA AVAILABILITY STATEMENT

Data are available upon request due to privacy/ethical restrictions.

DECLARATION OF INTEREST

The authors report no conflict of interest

ORCID

Nabeelah Nagdee https://orcid.org/0000-0001-9134-4690
Victor Manuel de Andrade https://orcid.org/0000-0002-7494-0527

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APPENDIX A: INTERVIEW GUIDE

Section I: Biographical Information

1. Gender:
   a) Female b) Male
2. Age: _____
3. Race and Ethnicity: (*circle one*)
   a) White/Caucasian b) African/Black c) Indian
   d) Coloured e) Other:_____
4. Please state your religion affiliation?
   a) Christian b) Hindu c) Jewish
   d) Muslim e) Other_____
5. Designation
   a) STA b) ST c) A
6. How long have you be practicing in the profession? _____

7a. Where were you practicing in the past?
7b. Where are your currently employed?

Section II: Patient Death and Dying

8a. Please recount a particular episode during which one of your patients died?
8b. Why does this specific encounter stand-out?
8c. What was most difficult about this experience?
9. In your experience, recount your encounters with bereaved significant others after the passing on of the patient?

Section III: Coping with Death and Dying

10. What coping mechanisms did you employ to aid you in overcoming the death of your patients?
11. In your experience, if any, what provision in your work setting was made to help you cope with the death and dying process of your patients?