

Moral distress and the importance of data

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A happy and healthy workforce delivers better care. That's the theory, although the evidence may be elusive. We do know, however, that an unhappy and unwell workforce delivers worse care. The pressures on the workforce are myriad and complex, but with COVID-19 cases rising, at the time of writing, we hear only of problems unsolved and neglect unacknowledged.

The workforce crisis is political in the sense that the politicians of the day must address it, and if they do not then their motives and decisions are questioned. Whether other governments would do a better job on the health workforce is unknown, but what is known is that the record of the current UK government is a bad one. Therefore, the workforce becomes political and doctors and other health professionals, when pitted against the government, are easily depicted as radicals.

One driver for the crisis in workforce wellbeing and retention, however, seems closer to the heart of the problem. In recent weeks, as international conferences have resumed, I've heard health professionals from many countries talk openly about the harm being caused by moral distress, the negative impact on health professionals of their inability to offer a minimum standard of care to patients. Moral distress is a universal phenomenon, and it needs to be more widely acknowledged and addressed.

Yet the distress being felt by health professionals has many dimensions. For instance, there is the effect of demonstrable bias in appointment of consultants.¹ It might manifest as a failure to stay updated on how to manage health professionals potentially exposed to HIV.² Or reveal itself in battles with technological solutions that overpromise and underdeliver.³ It may arise from difficulties in helping patients in primary

care take up lifestyle interventions.⁴ And is certainly exposed by the limited options to support patients with long covid.⁵

When we find ourselves in times of trouble, one way out of the distress is to begin with the data. Over the past decade, we've seen the growth and helpful impact of a sophisticated methodology called network meta-analysis. Read the story of how network meta-analysis originated, how it works, and how it should be used.⁶ Data can be political too, whether they are about moral distress, workforce, racism, technology, or COVID-19, but at least they form the basis of a constructive dialogue and debate.

References

1. Harvey PR, Phillips C, Newbery N, et al. Ethnic differences in success at application for consultant posts among United Kingdom physicians from 2011 to 2019: a retrospective cross-sectional observational study. *J R Soc Med* 2022; 300–312.
2. Asanati K, Majeed A, Shemtob L and Cresswell F. Healthcare workers potentially exposed to HIV: an update. *J R Soc Med* 2022; 286–288.
3. Cresswell K, Sheikh A and Williams R. 'Managed convergence' in health system digitalisation. *J R Soc Med* 2022; 284–285.
4. Lemp JM, Nuthanapati MP, Bärnighausen TW, et al. Use of lifestyle interventions in primary care for individuals with newly diagnosed hypertension, hyperlipidaemia or obesity: a retrospective cohort study. *J R Soc Med* 2022; 289–299.
5. Davies F, Finlay IB, Howson H and Rich N. Recommendations for a Voluntary Long COVID Registry. *J R Soc Med* 2022; 321–324.
6. Lee A. The development of network meta-analysis. *J R Soc Med* 2022; 313–321.