**Moral distress in recent time: a study with nursing professors working higher education institutions**

**Abstract**

The objective was to identify levels of moral distress nursing professors experienced in a recent period and to describe its association with sociodemographic characteristics. The sample of this quantitative, cross-sectional study was composed of 373 nursing professors working in federal public universities hosting undergraduate nursing programs in Brazil. Two instruments available online were used to collect data: Moral distress scale in nursing and the Moral Distress Thermometer. Statistical analysis included Pearson’s Chi-square to identify potential associations among variables and Analysis of Variance was used to compare means. A total of 93.4% (n=348) of the general population of nursing professors reported some level of moral distress in the two most recent weeks prior to the study. A significant association (p<0.05) was found between the “afflictive” level of moral distress, measured by the Moral Distress Thermometer, and sociodemographic data concerning age and region where professors’ universities are located. The conclusion is that this study contributes to the advancement of knowledge regarding moral distress, as it presents recent experiences of nursing professors, which can support actions and policies in this sphere.

Keywords: Nurse; Nursing education; Morale; Ethics, Nursing

**Introduction**

The definition of moral distress (MD) has evolved over time, but it basically corresponds to a form of anguish that takes place when a health worker feels unable to act in accordance with his/her ethical values and moral principles due to interpersonal or institutional obstacles1. The philosopher Andrew Jameton recognized it for the first time among nurses in 1984, which explains the centrality of studies in this population (1).

Moral distress may become acute or permanent in a work environment, once it produces an experience of moral transgression, of a psychological and ethical nature, which may result in anguish, fear, anger, lack of interest in activities, anxiety and insecurity (2). In general, some aspects are highlighted as potential triggers of distress, such as: lack of autonomy and power imbalance in labor relations; restricted resources; the delivery of futile care; incompetent workers in multidisciplinary teams; work overload; and inappropriate communication, among others (3).

In the academic teaching routine, it is common to find nursing professors dealing with situations of conflict. These situations demand a high level of scientific and ethical commitment to ground choices and decisions. Thus, ethics become extremely important to guiding the behavior and actions of individuals, toward themselves, others and the environment, especially because the practice of ethics leads to reflection and supports one’s beliefs and principles (4).

The decisions of nursing professors directly influence the care provided to patients and the solving of ethical problems, also influencing the learning process and professional development of students, who, because of a lack of experience and knowledge, are attentive to the attitudes and behaviors of professors (4).

In this context, some specific elements reported in the literature concerning the conditions and organization of teaching and that may trigger stress and distress, are highlighted, namely: task overload; demands from funding agencies; institutional policies; lack of autonomy; insufficient teaching training; strong appeal to be involved with scientific research and university extension activities; large number of students; assessment processes; and interpersonal conflicts (8-10).

Nonetheless, for these situations to be associated with moral distress, workers need to believe that their moral standards are being violated and, at the same time, feel unable to act otherwise. In view of this, the deleterious effects of moral distress can affect individuals in the short term and it depends on how long an individual continues to act in dissonance with his/her ethical values and moral principles (11).

Therefore, teaching in the nursing field is a topic that needs to be explored, considering that not being able to behave in accordance with one’s beliefs in a professional context renders the learning-teaching process incoherent, especially because nursing is a specialty of reference in the training of future professionals.

Additionally, the possibility of identifying moral distress in the period immediately prior to the study can provide important insights about problems recently faced in institutions and contribute to implement effective strategies.

This study is expected to encourage reflection upon the ethical behavior of nursing professors regarding themselves and their activities, in addition to providing a direction to new research in order to support the planning of efficacious interventions, based on the understanding of situations triggering moral distress among workers in this profession. This study’s objective was to identify levels of moral distress among Brazilian nursing professors and describe its association with sociodemographic characteristics.

**Research design**

This is a cross-sectional quantitative study (14).

Setting and participants

This study was conducted in Brazilian public federal universities and addressed 373 nursing professors teaching in undergraduate nursing programs. Inclusion criteria were: being an effective nursing professor; teaching in undergraduate nursing programs for at least six months, regardless of teaching in graduate nursing programs; not being on any kind of leave; and being available to participate in this study and interested in doing so.

Calculation of sample size took into account a specific formula14 based on estimating a proportion of the population, which was intended to estimate the minimum relevant size necessary to perform certain statistical procedures so that a minimum sample of 264 informants was achieved.

Data collection

Data were collected between June and December 2018 using a digital tool available free of cost from Google Docs sent via email to nursing professors teaching in undergraduate nursing programs. The lists of nursing schools and colleges were obtained from the website of each teaching institution, while the professors’ contact information was provided by the programs’ coordinators.

The messages sent via email included information concerning the study’s objectives, a link to the form, instructions on how to complete the form, a free and informed consent form, and a deadline (four weeks) to complete the form. A new email was sent every week to those who had not responded, but once access to the system ceased, no additional data were collected.

Instruments

Two instruments were used to collect data: the first, a reliable instrument to analyze intensity of distress, the *Escala de sofrimento moral para enfermeiros docentes (ESMED)a* [Moral distress scale in nursing], was the basis for identifying the constructs related to moral distress, previously validated with 30 questions assessed on a five-point Likert scale.

This instrument assesses intensity of moral distress based on six constructs: work overload; self-perception of low professional qualification; limitations faced in college teaching; organizational limitations; parrhesia; and perception of poor teaching quality. The instrument’s reliability was confirmed with a Cronbach’s alpha equal to 0.925. Intensity of MD was verified through the means obtained for each of the instrument’s six factors and the general MD mean by considering the six constructs together.

The second instrument is called the Moral Distress Thermometer (MDT)15 and is composed of a visual scale with a single item with a score of 11 points, ranging from 0 to 10. The scale includes words to support the identification of different levels of MD, ranging from “none” to “worst possible”.

The instrument provides a definition of MD and instructions for respondents to reflect upon their practice of recent weeks and identify their level of MD, choosing a number that best represents it on the thermometer15. MD levels are classified by the MDT as follows: (0) none; (1,2) mild; (3,4) uncomfortable; (5,6,7) afflictive; (8,9) intense; and (10) worst possible.

Data analysis

Data analysis was operationalized by exporting the completed instruments from the Google Docs platform to Excel® 2016, which were then compiled and transferred to the Statistical Package for the Social Sciences - SPSS, version 24.0.

The categorical variables were summarized using descriptive statistics (absolute and relative frequencies). Person’s Chi-square test was used to assess associations between the nominal variables of interest and MD levels, while ANOVA was used to check the differences between the means obtained for continuous variables in the condition classified as “afflictive,” according to the MD thermometer. A confidence level of 95% and significance of 5% (p-value≤0.05) was adopted in this study.

Ethical consideration

Ethical aspects were in accordance with the guidelines established by Resolution 466/12, the Brazilian Council of Health, regulating studies involving human subjects. This study was approved by the Institutional Review Board.

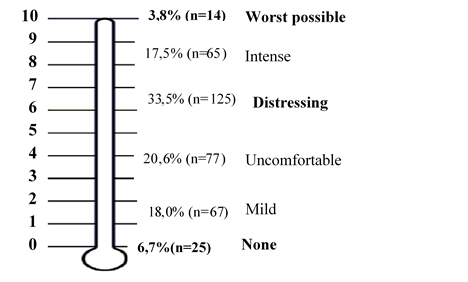
**Findings**

Recently experienced moral distress and sociodemographic characteristics

A total of 373 nursing professors took part in this study, 86.1% of whom were women (n=321) and 13.9% (n=52) were men, aged 43.36 years old (SD=10.52); with a minimum of 26 and maximum of 71 years old. Experience teaching in the higher education institution, in years, was an average of 10.54 years (SD=9.51), with a weekly workload of 40 hours: 90.9% (n=339) worked full time and were exclusively dedicated to teaching, research, extension and institutional management.

In addition to the activities concerning the undergraduate program, 72.9% (n=272) of the nursing professors also teach in graduate programs. In these cases, association between sociodemographic characteristics and MD levels was significant only for the age variable (p=0.048).

In regard to general levels of MD experienced by nursing professors in the last two weeks, the following answers were provided to each level presented in the thermometer, as presented in Figure 1.



**Figure 1:** Scores obtained on the MDT for MD in the recent period.

Note: The instrument’s authors authorized its use (Wocial & Weaver, 2013)

From this perspective, the highest percentage of answers provided by the professors, 33.5% (n=125), shows an “afflictive” level of MD, indicated by levels 5, 6 and 7 on the thermometer. The MDT shows that most of the nursing professors, 93.4% (n=348), reported some level of MD.

As for the geographic distribution of these participants, the location by region for the institutions with which the participants are affiliated was statistically significant (p=0.049). Thus, based on the fact that the highest number of answers, that is, 125 nursing professors checked the option “afflictive”, we sought to verify whether this was associated with Brazilian regions and found the following distribution according to professors who have experienced an afflictive level of distress: north N=7 (5.6%); midwest N=9 (7.2%); northeast N=20 (16%); southeast N=43 (34.4%) and south N=46 (36.8%).

Means of moral distress related factors

In regard to the assessment of the effects of the six constructs, statistically significant differences (p<0.01) were found for all means in relation to the “afflictive” level represented on the thermometer and its association with MD.

As a result, the constructs Organizational limitations (2.65; SD 0.81) and Parrhesia (2.63; SD 0.28) obtained the highest means, when compared to the MD “afflictive” level indicated on the thermometer, followed by Work overload (2.39; SD=0.78); Perception of poor pedagogical quality (2.34; SD=0.73); Restrictions imposed on work within the university (2.17; SD=0.94); and Self-perception of low professional qualification (1.38; SD=0.88).

**Discussion**

Comparison tests of means and association tests were used to test the hypothesis that high levels of MD, represented by the “afflictive” level, would be related to categorical variables such as sex, age, graduate teaching, time working in the HEI, and region, in addition to the constructs concerning situations that trigger distress. Hence, in regard to sociodemographic data, only the variables age and region were statistically significant in this study.

Nursing professors who used the thermometer and rated the activities they performed in the last two weeks as “afflictive” were 38.50 (SD=8.36) years old on average ,while those who checked “none” were aged 47.88 (SD=11.57) years old on average.

These results are statistically significant and are important for nursing practice to the extent they suggest younger workers experience higher levels of MD, a finding that corroborates studies reporting there is an association between younger nurses and professors and experiences of stress and distress. It appears younger workers are more affected by not having yet acquired efficient coping mechanisms (16-18).

Reports in the literature reveal that nurses experience stressful and distressing situations6-18 and, in general, show that younger workers may not have acquired the necessary skills to identify and deal with MD. Older workers, in turn, more easily recognize MD-triggering situations in their practices and have already developed more efficient coping strategies (17).

A significant association was found between the regions in which the federal public undergraduate nursing programs are located and levels of MD (p<0.05). A higher percentage of individuals chose the “afflictive” level of MD in the south 36.8% (n=46) and southeast 34.4% (n=43), respectively.

Considering the geographic distribution of Brazilian Higher Education Institutions providing undergraduate nursing programs according to federative unit, a mapping study reports that programs present the highest geographical concentration in the southeast, followed by the northeast, south, midwest, and north. These institutions have in common a strong call for changes and improvements in the teaching of health, especially in regard to the training of nurses, who need increasingly better training to meet the health needs of the population (21).

In regard to the expansion of undergraduate nursing programs, the south still presents a median number of HEI, when compared to expansion experienced by other regions, considering that industrial development leads to a greater demand for qualified services21. Nonetheless, there is an increasing number of studies addressing MD in the field of nursing, with different research groups active in this region (17).

Most of the studies addressing MD in the southern region of Brazil have focused on the intensity and frequency of MD among nurses associated with potential situations of conflict faced in the context of care settings17. The main factors reported include: lack of competence on the part of the work team; interpersonal conflicts; disregard for patient autonomy; poor working conditions; and low professional autonomy (8).

Note that the highest number of studies addressing MD is in the south and the highest number of individuals reporting an afflictive level of MD is also in this region, suggesting that this moral dimension has been acknowledged among these workers as part of their occupational routine.

Therefore, the high number of studies addressing MD in the south gives it greater visibility and may favor clearer perception and recognition of this phenomenon as an ethical problem that is present in the work routines of nurses, especially because these workers have experienced it longer than those in other regions. Therefore, this study’s participants living in other Brazilian regions may not recognize certain problems as part of an ethical dimension (22).

It is important to keep in mind that moral issues, such as situations that lead to moral reflection and that lead workers to question themselves and their own lives, considering that moral issues arise from their own practice, take place in an environment where there is a lack of trust, while standards and rules do not support decision-making based on workers’ ethical, personal and professional values, triggering conflict and feelings of anguish that need to be ressignified (22).

Conditions in which nurses have no opportunity to be autonomous and resist situations of conflict (22) may lead to moral distress, especially when an individual has to perform an activity s/he recognizes as in conflict with his/her moral values.

On the other hand, the southeast region, given its large population, with the highest concentration of income in the country, hosts the largest number of nursing programs in Brazil, which reveals regional inequalities and an overload of activities faced by professors in this field (21).

The global score of responses provided by the nurses to the thermometer was calculated (15), and as previously mentioned, “afflictive” moral distress obtained the highest number of responses, followed by “mild” and “worst possible”. Most, 93.4% (n=348), perceived some level of MD in recent weeks; that is, a considerable number of individuals experienced MD in recent time.

These results are similar to the findings reported by other studies addressing nurses working in clinical settings, showing there is a considerable number of workers who experience or have already experienced MD over the course of their professional lives (19,23).

It is important to note that there is a relationship between repeated experiences of MD and the intensity of MD. Workers who have experienced MD at least once are more likely to experience it again, given that it permeates the work environment and is not limited to a single event (19,24).

Therefore, the presence of moral distress at an afflictive level is a warning, especially because it indicates that workers faced challenging situations in the educational context in the recent past, which need to be discussed and subject to intervention. Another alternative to use the MDT is proposed by a study conducted with physicians and nurses from a hospital located in Indianapolis, USA, in which the instrument was used to obtain and monitor levels of MD over time as interventions were implemented (25).

Regarding MD-related constructs, they correspond to different situations nurses experience in their work and that may cause the phenomenon. All six constructs were statistically significant (p<0.01) because they express the main factors associated with high levels of anguish. Analysis of variance enabled comparing the different means obtained for the constructs; having the MDT “afflictive” level served as the parameter.

Thus, aspects related to institutions are identified as causing distress among nursing professors. In this study, they correspond to Organizational limitations, globally represented by physical structures that are inadequate for teaching, such as supervised training fields not conducive to teaching; a lack of material resources; and health teams that are unprepared to provide quality care to patients. From this perspective, this context in Brazil is similar to that found in other countries, and seems to reveal that doing more with less has become the norm in the teaching of nursing (24).

Information reported in the literature regarding organizational limitations frequently refers to settings where practical teaching is provided to students, because these associate stressing elements such as structural setbacks, managing and supervising a high number of students, and the mediation of conflicts among workers in the health services where teaching activities take place (5).

In regard to parrhesia, a concept rescued by the philosopher Michel Foucault, it refers to a specific modality of veracity, a way of being, similar to virtue, in the context of asymmetrical power relationships, which allows individuals to position themselves actively and confront dominant discourses and procedures instead of reproducing them. In fact, in parrhesia, speakers use their freedom and choose frankness over persuasion, truth over lie or silence, risk over safety, criticism over praise, and moral duty over self-interest (26,27).

In this study, in response to parrhesia-related questions, nursing professors seem to recognize the need for there to be coherence among thought, speech and action, always ethically committed to their personal and professional values. In their daily practice, however, they face difficulties implementing this behavior when facing organizational problems, especially when there are potential risks (26). Therefore, there is an apparent distinction between how these workers wanted to behave and how they actually behave; as a consequence, they experience higher levels of distress.

Similarly, some studies addressing the experience of nurses in dealing with moral distress concluded that these individuals often employ evasive strategies to cope with distressing issues, without directly confronting them, even when the need for confrontation is identified (19). In other words, when they recognize ethical issues, given the influence of social or organizational factors, they avoid establishing a candid dialogue with their co-workers or superiors (19).

One international study involving nursing workers and addressing fear of reprisals in the workplace, reports that choosing not to speak up when facing ethical problems is directly related to the following: fear of disagreement with superiors; fear of breaking interpersonal relationships; and fear of reprisals. The study also concluded that the fear reported by workers provides a clue of MD, especially because it suggests an organizational culture that represses ethical practices (23).

In regard to the construct Work overload, it appears associated with higher levels of MD in the work routine of nursing professors. This finding is in agreement with a large number of studies indicating that work overload in higher education institutions is one of the main reasons for illnesses among professors (5,9,24,28-30).

In general, these studies deal with professors working full time (40 weekly hours), whose number of activities increase due to the various demands concerning teaching, research, extension, and management, which often take them beyond the physical environment of universities, reaching more than 60 weekly hours, in three shifts. Therefore, for these workers to remain productive, they end up sacrificing leisure and rest, compromising their physical and mental health (28-30).

Thus, the possibility of not being able to provide quality teaching to undergraduate students due to a lack of time caused by task overload, becomes a source of anguish among nursing professors, similar to the context faced by nurses in hospital settings. These workers feel unable to provide appropriate care to the population given the number of tasks they have to perform. Thus, when work loses its essential meaning, in either of these two settings, MD may become a reality among workers (25,28).

In regard to the construct Limitations faced within universities, nursing professors report situations related to lack of respect on the part of undergraduate students and hierarchical superiors. These situations may be better understood if we consider results reported in the literature that relate stress, devaluation, and distress in the workplace with events arising from the attitudes of students, co-workers and from the institutions’ structure (5).

Disrespect and devaluation experienced by professors has contributed to MD and may be linked to a divergence between the ideal quality of the learning-teaching process that professors desire and the uncooperative and even disrespectful behavior of students. In this context, professors understand that theoretical-practical teaching to be essential during the undergraduate program for students to experience what it means to be a nurse, and for it to occur, students need to engage in the activities proposed, in an ethical and humanized way (5, 31).

Thus, other situations that may also trigger MD in academic environments are revealed in the context of conflicting relationships established between professors and managers, mainly determined by a lack of autonomy. In this case, the literature shows that not being able to take part in decision-making and the dominant behavior of superiors in terms of work dynamics, may lead workers to submit themselves to rigid rules and standards that often are not congruent with their moral values and beliefs (32).

In regard to the Perception of low pedagogical quality and Self-perception of low professional qualification, the effects of MD were less intense; unfavorable implications that are important for teaching practice, though, are not thereby discarded. The professors identified deficiencies in their own teaching-pedagogical training and in their colleagues’ training.

In this sense, it appears that studies addressing teaching practice are still incipient and are opposed to the outdated understanding that to be a professor, mastering certain knowledge in specific areas of activity is sufficient, without the need for pedagogical training (32,33).

One exploratory study composed of 85 professors teaching in ten undergraduate nursing programs located in the south of Brazil reports that the professionals, specialized in some specific area of knowledge, were in general apt to perform teaching activities in different fields of knowledge in health, however, lacked pedagogical training and expressed difficulties in the teaching-learning process (29).

These results have implications related to the *Lei de Diretrizes e Bases da Educação Nacional* (LDB – Lei 9.394/96) [Guidelines and Bases of National Education Law], by providing that teaching training for higher education programs should be provided in graduate programs, both at the Master’s and doctoral levels. Graduate programs, however, emphasize the training of researchers at the expense of focusing on training regarding teaching. As a consequence, a large number of professors enter undergraduate programs without having proper training in teaching (4).

Therefore, when becoming a mediator of the process of production and transformation of knowledge, nursing professors are advised to be imbued with knowledge of sciences that are related to education, methodology and specific nursing competencies in order to ensure continuous knowledge involved with innovations emerging from the professional and social context34.

**Strengths and limitations**

Certain limitations should be taken into account when interpreting this study’s results. Ideally, the number of participants should be higher in terms of active nursing professors. There is also a lack of studies addressing moral distress in the context of nursing professors, hindering the discussion of results.

A positive aspect, however, is the fact that this study presents new knowledge regarding the context of Brazilian nursing professors and their experiences with MD in the recent past. Note that a significant number of workers experienced some level of MD.

**Conclusion**

Reflecting upon the teaching activities performed in the recent past can promote self-transformation and significantly contribute to nursing professors remaining morally engaged with their activities. Additionally, recognizing the existence of MD and the need for changes involves ethical work upon oneself, which can strengthen knowledge and essential skills to cope with morally distressing situations.

Note that the need for changes cannot fall on professors only. Higher education institutions also need to be involved in this reflexive-transformative process, as they play a crucial role in providing structures, environments, and policies that are conducive to the teaching-learning process in the fields of education and health,

From this perspective, institutions need to be aware of this phenomenon and be prepared to provide workers with morally accessible environments by encouraging, guiding and recognizing the various ethical issues and ways to intervene, even at the risk of facing constraints.

Additionally, further studies are suggested to address the use of the Moral Distress Thermometer as a tool to monitor and validate strategies.

Conflicts of interest

Declaration of interest none.

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**Note**

a. ESMED is the acronym for the *Escala de Sofrimento Moral para Enfermeiros Docentes*, in which E stands for *Escala* [Scale], S stands for *Sofrimento* [Distress], M for *Moral* [Moral], E stands for *Enfermeiros* [Nurses], and D stands for *Docentes* [Professors]. In English, it reads “Moral Distress Scale for Nursing Professors”.

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