

Research Article

Moral Distress among Healthcare Workers in Paediatric Intensive Care Units in Sri Lanka: A Cross-Sectional Study

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Abstract

Background: When institutional or contextual limitations prevent healthcare professionals from acting in accordance with their ethical values, moral distress results. Due to difficult moral choices, emotional demands, and scarce resources, paediatric intensive care units (PICUs) are especially susceptible to moral distress. There is still a dearth of data from low- and middle-income nations like Sri Lanka.

Objectives: To find out how common moral distress is among healthcare professionals in PICUs in Sri Lanka and how it relates to their professional quality of life.

Methods: From April to October 2025, physicians, nurses, and physiotherapists with at least six months of PICU experience participated in a descriptive cross-sectional study. A self-administered questionnaire comprising sociodemographic and work-related variables, the Professional Quality of Life Scale (ProQOL-5), and the Moral Distress Scale-Revised (MDS-R) was used to gather data. SPSS version 24 was used to analyse the data, and $p < 0.05$ was chosen as the statistical significance level.

Results: A total of 306 healthcare professionals (mean age 39.99 ± 7.10 years), mostly nurses (80.1%) and women (91.1%), took part. Mild moral distress was indicated by the mean moral distress score of 21.44 ± 7.76 . The majority of participants reported low levels of burnout (86%) and secondary traumatic stress (86%), as well as average compassion satisfaction (70%). Burnout, secondary traumatic stress, compassion satisfaction, and professional or demographic traits did not significantly correlate with moral distress. On the other hand, there was a significant correlation ($p = 0.008$) between increased secondary traumatic stress and longer weekly working hours. There were very few opportunities for structured debriefings (4.0%) and ethics training (2.6%).

Conclusion: Healthcare professionals in Sri Lankan PICUs have a generally positive professional quality of life despite experiencing mild moral distress. Employee well-being may be further improved by bolstering institutional support through workload management, debriefing procedures, and ethics education.

Keywords: moral distress, healthcare workers, paediatric intensive care unit, professional quality of life, Sri Lanka.

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Introduction

The term "moral distress" was first introduced in nursing ethics by Jameton, who described it as the psychological disequilibrium that occurs when an individual knows what is morally right but is unable to act on it due to institutional or contextual constraints [1]. Over time, this phenomenon has been observed in various healthcare settings and professions, particularly in intensive care environments where complex clinical decisions and ethical dilemmas are prevalent. Clinicians are particularly vulnerable to moral distress because of the rapidly advancing technology in paediatric intensive care units (PICUs) and the emotional connections they form with critically ill children and their families.[2] Conflicts with institutional expectations, disagreements with families, perceived futility of care, and repeated exposure to end-of-life dilemmas all intensify this experience.

In health systems with limited resources, such as Sri Lanka, issues like low staffing, high patient loads, inadequate equipment, and hierarchical decision-making norms further contribute to moral distress. Systemic limitations often hinder the provision of care that aligns with personal or professional values, and junior employees frequently lack a voice in ethical discussions. This unresolved moral distress can accumulate, leading to burnout, compassion fatigue, emotional exhaustion, and a decline in the quality of patient care [3]. International research indicates that higher levels of moral distress are linked to lower job satisfaction, reduced professional quality of life, increased intentions to leave one's job, and poorer psychological health [4].

Despite being widely recognised as a significant workforce issue, there remains limited data from low- and middle-income countries. Although PICUs are among the most emotionally challenging and ethically complex clinical settings, there is a lack of research on moral distress in these environments in Sri Lanka. Understanding the prevalence of moral distress and its associations with demographic, occupational, and psychological factors is essential for guiding contextually appropriate interventions, reinforcing ethical practices, and enhancing staff well-being [2]. Therefore, this study aims to assess the prevalence, contributing factors, and consequences of moral distress among medical staff in PICUs in Sri Lanka.

Methods

A descriptive cross-sectional study was conducted among healthcare workers in PICUs in Sri Lanka. The study period was from April to October 2025. Eligible participants included doctors, nurses, and physiotherapists with a minimum of six months of continuous experience in all dedicated PICUs in Sri

Lanka, including the Medical Intensive Care Unit (MICU) and Cardiac Intensive Care Unit (CTICU) at Lady Ridgeway Hospital for Children, National Hospital Karapitiya, Sirimavo Bandaranaike Specialist Children Hospital Peradeniya, Teaching Hospital Kurunegala, and Teaching Hospital Anuradhapura. Administrative staff, non-clinical workers, and individuals on long-term leave or diagnosed with depressive or anxiety disorders were excluded.

The sample size was calculated based on a 34.2% prevalence of burnout reported in the literature [2], resulting in a sample of 384 participants. Due to the limited staffing in PICUs across Sri Lanka, convenience sampling was employed, inviting all eligible healthcare workers. Ultimately, 306 completed responses were included in the analysis. Since there was no local data on the prevalence of moral distress, the sample size was estimated using burnout prevalence figures from similar critical care environments, as burnout is closely linked to moral distress and professional quality of life.

Data collection employed a self-administered questionnaire consisting of three sections: (1) sociodemographic and work-related variables; (2) the Moral Distress Scale-Revised (MDS-R), consisting of frequency and intensity components; and (3) the Professional Quality of Life Scale (ProQOL-5), which measures compassion satisfaction, burnout, and secondary traumatic stress. The MDS-R is a score given to measure moral distress in research or clinical practice. It is calculated by multiplying each item's frequency and intensity, then summing across all items, yielding a total score ranging from 0–336. The MDS-R, an updated version of the original Moral Distress Scale (MDS) developed by Corley in 2001, was published in 2012 by Hamric, Borchers, and Epstein. [5] Designed as a practical, multidisciplinary tool for assessing moral distress among healthcare professionals, the MDS-R aims to offer a more comprehensive and user-friendly assessment. ProQOL subscales were scored according to standardised guidelines, with established cut-offs defining low, moderate, or high levels [5]. The internal consistency and reliability for the MDS-R was acceptable (Cronbach's alpha = 0.71), while the ProQOL-5 scale demonstrated good reliability (Cronbach's alpha = 0.87). Since there were no Sinhala versions of both instruments, they were translated back into the native language and then into English with the help of experts, using the forward-backward translation method. Experts in the field ensured that these questionnaires were properly adapted to the culture. These questionnaires have undergone pilot testing among ten healthcare workers and have been assessed for relevance and clarity.

Both the above scores are commonly used to measure burnout and have been adapted to local culture, making

them more appropriate for use in Sri Lanka. Data were entered into a secure spreadsheet and analysed using SPSS version 24. Descriptive statistics summarised participant characteristics. Correlation analysis assessed associations between moral distress scores and psychological outcomes. Group comparisons were made using chi-square tests, independent t-tests, or ANOVA where appropriate. A p-value of <0.05 was considered statistically significant. Ethical approval was obtained from the Ethics Review Committee of the

Postgraduate Institute of Medicine, Sri Lanka (ERC/PGIM/2025/114).

Results

A total of 306 healthcare workers participated, with a mean age of 40.0 ± 7.1 years. Most respondents were female (91.1%). Most participants (86.8%) were married, and the majority held diploma-level educational qualifications (64.6%). Buddhism was the predominant religion (92.4%). (Table1)

Table 01: Demographic factors of healthcare workers in paediatric intensive care units.

Demographic factor	n (%) or Mean $\pm$ SD
Age (years) (n = 306)	39.99 $\pm$ 7.10
Gender (n = 305)	
Male	27 (8.9)
Female	278 (91.1)
Marital status (n = 303)	
Married	263 (86.8)
Unmarried	27 (8.9)
Divorced	6 (2.0)
Widowed	7 (2.3)
Highest educational qualification (n = 305)	
Diploma	197 (64.6)
Bachelor's degree	79 (25.9)
Postgraduate degree	21 (6.9)
Postgraduate diploma	8 (2.6)
Religion (n = 302)	
Buddhism	279 (92.4)
Christianity / Roman Catholic	16 (5.3)
Islam	1 (0.3)
Hinduism	6 (2.0)

SD - standard deviation.

Regarding work-related factors (Table 2), 46.0% of participants had more than five years of PICU experience, and most respondents were nurses (80.1%). Also, 42–84 working hours per week were reported by

nearly half of the sample (49.4%). Only 2.6% had received ethical decision-making training, and 4.0% had participated in debriefing or support groups.

Table 02: Work-related factors of healthcare workers in paediatric intensive care units.

Work-related factor	n (%)
Profession (n = 306)	
Doctor	58 (19.0)
Nurse	245 (80.1)
Physiotherapist	3 (1.0)
Years of experience in the healthcare sector (n = 305)	
< 2 years	10 (3.3)
2–5 years	27 (8.9)
5–10 years	80 (26.2)
10–20 years	138 (45.2)
> 20 years	50 (16.4)
Years of experience in PICU (n = 301)	
< 6 months	6 (2.0)

6 months – 1 year	41 (13.6)
1–3 years	42 (14.0)
3–5 years	73 (24.3)
> 5 years	139 (46.2)
Working hours per week in the ICU (n = 302)	
< 42 hours	139 (46.0)
42–84 hours	158 (52.3)
> 84 hours	5 (1.7)
Training on ethical decision-making or moral distress (n = 305)	
Yes	8 (2.6)
No	297 (97.4)
Participation in support groups and/or debriefing sessions (n = 302)	
Yes	12 (4.0)
No	290 (96.0)

The mean moral distress score was 21.4 ± 7.8 , indicative of mild moral distress. Levels of professional quality of life revealed that 70% of participants experienced average compassion satisfaction, 86% had low burnout, and 86% had low secondary traumatic stress (Table 3).

Table 03: Levels of compassion satisfaction, burnout, and secondary traumatic stress.

Outcome	Level	Frequency (%)
Compassion satisfaction (n = 305)	Low	0 (0.0)
	Average	212 (69.5)
	High	93 (30.5)
Burnout (n = 305)	Low	255 (83.6)
	Average	50 (16.4)
	High	0 (0.0)
Secondary traumatic stress (n = 305)	Low	262 (85.9)
	Average	43 (14.1)
	High	0 (0.0)

Correlation analyses demonstrated no statistically significant associations between moral distress and compassion satisfaction ($r = 0.06$, $p = 0.59$), burnout ($r = 0.03$, $p = 0.31$), or secondary traumatic stress ($r = 0.09$, $p = 0.11$). Similarly, no demographic factor was significantly associated with levels of moral distress.

Table 4 summarises the associations between secondary traumatic stress and key variables, showing only working hours per week as statistically significant ($p = 0.01$). Notably, longer weekly working hours were significantly associated with higher levels of secondary traumatic stress ($p = 0.008$).

Table 4: Association between the level of secondary traumatic stress and demographic and work-related factors.

Factor	Low STS n (%) (N = 262)	Average STS n (%) (N = 43)	Statistic	df	P value
Age (years), Mean $\pm$ SD	39.9 $\pm$ 7.4	40.2 $\pm$ 4.5	—	—	0.44
Gender					
Male	25 (9.2)	2 (4.7)	$\chi^2 = 1.11$	1	0.39
Female	236 (89.8)	41 (95.3)			
Marital Status			$\chi^2 = 5.63$	3	0.13
Married	223 (84.8)	40 (93.0)			
Unmarried	26 (10.0)	0 (0.0)			
Divorced	6 (2.3)	0 (0.0)			
Widowed	6 (2.3)	1 (2.3)			

Highest educational qualification			$\chi^2 = 5.89$	3	0.12
Bachelor's degree	72 (91.1)	7 (8.9)			
Postgraduate degree	17 (81.0)	4 (19.0)			
Postgraduate diploma	5 (62.5)	3 (37.5)			
Diploma	167 (85.2)	29 (14.8)			
Religion			$\chi^2 = 2.16$	3	0.54
Buddhism	236 (84.9)	42 (15.1)			
Christianity/Roman catholic	15 (93.8)	1 (6.3)			
Islam	1 (100.0)	0 (0.0)			
Hinduism	6 (100.0)	0 (0.0)			
Profession			$\chi^2 = 0.59$	2	0.74
Doctor	49 (84.5)	9 (15.5)			
Nurse	210 (86.1)	34 (13.9)			
Physiotherapist	3 (100.0)	0 (0.0)			
Years of experience in healthcare			$\chi^2 = 5.65$	4	0.23
< 2 years	10 (100.0)	0 (0.0)			
2–5 years	26 (96.3)	1 (3.7)			
5–10 years	69 (86.3)	11 (13.6)			
10–20 years	116 (84.7)	21 (15.3)			
> 20 years	40 (80.0)	10 (20.0)			
Years of experience in PICU			$\chi^2 = 3.56$	4	0.47
< 6 months	4 (66.7)	2 (33.3)			
6 months–1 year	38 (92.7)	3 (7.3)			
1–3 years	36 (85.7)	6 (14.3)			
3–5 years	63 (86.3)	10 (13.7)			
> 5 years	117 (84.8)	21 (15.2)			
Working hours per week in the ICU			$\chi^2 = 9.72$	2	0.01
< 42 hours	128 (92.1)	11 (7.9)			
42–84 hours	128 (81.5)	29 (18.5)			
> 84 hours	3 (60.0)	2 (40.0)			
Night shifts per month			$\chi^2 = 1.12$	2	0.57
< 8	175 (87.1)	26 (12.9)			
8–16	80 (83.3)	16 (16.7)			
> 16	3 (75.0)	1 (25.0)			
Training on ethical decision-making			$\chi^2 = 3.69$	1	0.09
Yes	5 (62.5)	3 (37.5)			
No	256 (86.5)	40 (13.5)			
Participated in support/debriefing sessions			$\chi^2 = 0.36$	1	1.00
Yes	11 (91.7)	1 (8.3)			
No	247 (85.5)	42 (14.5)			

STS = Secondary Traumatic Stress.

Burnout levels also showed no significant relationships with age ($p = 0.66$), gender ($p = 1.00$), education ($p = 0.06$), profession ($p = 0.64$), years of experience ($p = 0.20$), or religion ($p = 0.42$) (Table 5).

Table 05: Association between level of burnout with demographic and work-related factors.

Factor	Low Burnout n (%) (N = 255)	Average Burnout n (%) (N = 50)	Statistic	df	P value
Age (years), Mean $\pm$ SD	40.0 $\pm$ 7.4	40.1 $\pm$ 5.5	—	—	0.66
Gender			$\chi^2 = 0.06$	1	1.00
Male	23 (85.2)	4 (14.8)			
Female	231 (83.4)	46 (16.6)			
Marital Status			$\chi^2 = 4.64$	3	0.20
Married	216 (82.1)	47 (17.9)			
Unmarried	25 (96.2)	1 (3.8)			
Divorced	6 (100.0)	0 (0.0)			
Widowed	6 (85.7)	1 (14.3)			
Highest educational qualification			$\chi^2 = 7.48$	3	0.06
Bachelor's degree	69 (87.3)	10 (12.7)			
Postgraduate degree	17 (81.0)	4 (19.0)			
Postgraduate diploma	4 (50.0)	4 (50.0)			
Diploma	164 (83.7)	32 (16.3)			
Religion			$\chi^2 = 2.84$	3	0.42
Buddhism	229 (82.4)	49 (17.6)			
Christianity/Roman catholic	15 (93.8)	1 (6.3)			
Islam	1 (100.0)	0 (0.0)			
Hinduism	6 (100.0)	0 (0.0)			
Profession			$\chi^2 = 0.90$	2	0.64
Doctor	47 (81.0)	11 (19.0)			
Nurse	205 (84.0)	39 (16.0)			
Physiotherapist	3 (100.0)	0 (0.0)			
Years of experience in the healthcare sector			$\chi^2 = 6.04$	4	0.20
< 2 years	10 (100.0)	0 (0.0)			
2–5 years	22 (81.5)	5 (18.5)			
5–10 years	67 (83.8)	13 (16.3)			
10–20 years	118 (86.1)	19 (13.9)			
> 20 years	37 (74.0)	13 (26.0)			
Years of experience in PICU			$\chi^2 = 4.63$	4	0.33
< 6 months	4 (66.7)	2 (33.3)			
6 months–1 year	35 (85.4)	6 (14.6)			
1–3 years	32 (76.2)	10 (23.8)			
3–5 years	65 (89.0)	8 (11.0)			
> 5 years	115 (83.3)	23 (16.7)			

Overall, the results highlight that although moral distress was common, its severity was mild, and psychological outcomes were generally favourable. This is a good response relevant to the global literature, which shows severe distress levels. The above results may be due to cultural underreporting, which could be a result of the normalisation of emotionally challenging situations among healthcare professionals. The above

tools may not be sensitive to culturally specific expressions in distressing situations. Most participants reported a strong sense of compassion satisfaction, with low rates of burnout and secondary traumatic stress. However, it is important to note that the participants who underwent longer working hours were more likely to experience secondary traumatic stress ($p = 0.01$). This underscores the importance of institutional efforts

to provide support and optimise working schedules. This study also shows that very few staff members had access to ethical training or structured debriefing and support programmes. However, gaps in institutional support, particularly regarding ethics training and structured debriefing opportunities, should be addressed with targeted interventions.

Discussion

This study demonstrates a significant understanding of moral distress among healthcare workers in Sri Lankan PICUs, highlighting that mild levels of moral distress were widespread. The findings align with global evidence that PICU clinicians frequently encounter ethically challenging situations that may not always result in high moral distress scores but contribute to cumulative emotional strain [5,6].

In our study, we note relatively low levels of moral distress compared to the international literature. The most likely explanations for this occurrence are the normalisation of ethically challenging situations, cultural norms that prevent the expression of distress, and the limitations of the tools available in the country.

Consistent with the international literature, nurses in this study accounted for the majority of the workforce and reported more frequent involvement in ethically problematic clinical scenarios [7]. Although between-profession analyses were not statistically significant, existing research suggests that nurses often experience higher moral distress due to limited decision-making autonomy and closer proximity to patients and families [8,9]. Cheung et al. [8], for example, observed significantly higher median moral distress scores among nurses (102) compared with doctors (47) and allied health professionals (20), with distress correlating positively with symptoms of depression ($r = 0.45$, $p = 0.01$) and anxiety ($r = 0.42$, $p < 0.05$). Similar trends were documented in the United Kingdom by Boulton et al. [10], who found that nurses scored higher on moral distress (117.0, IQR 65.5) than doctors (78.0, IQR 73.0; $p = 0.02$). Although our study did not observe significant differences, this may be attributed to the homogeneity of the sample, cultural factors that suppress the expression of distress, or the majority being diplomate nurses with stable work experience.

Contrary to the findings of Almutairi et al. [11], who reported that younger healthcare workers (<37 years) experienced significantly higher moral distress ($p = 0.02$), our study found no association between age or experience and moral distress. This aligns with Sannino et al. [12] and Grasso et al. [13], who found no correlation between moral distress and years of professional experience. Nearly half of the participants in the present study had over five years of PICU

experience, which may contribute to a stabilised psychological response to ethical stressors.

A striking finding was the very low level of institutional support: only 2.6% had received ethical decision-making training, and just 4% had participated in debriefing sessions. International guidelines advocate for structured ethics rounds, debriefings, and moral case deliberations to reduce moral distress [9,10]. Rodriguez-Ruiz et al. [14] demonstrated a significant inverse correlation between moral distress and ethical climate ($r = -0.28$, $p < 0.001$), highlighting the role of institutional culture. Similarly, Deschenes et al. [15] pointed out communication failures and hierarchical structures as major contributors to moral distress in paediatric intensive care.

The mean moral distress score (21.4 ± 7.8) was not significantly correlated with compassion satisfaction, burnout, or secondary traumatic stress, although weak positive relationships were present. These results suggest the resilience within the Sri Lankan PICU workforce. Comparable results were found in the Canadian study by Dryden-Palmer et al. [2], which reported low overall moral distress despite the prevalence of ethically troubling situations. However, Saleh et al. [16] and Sodowick [17] have shown that even low to moderate moral distress can occur, subsequently manifesting as compassion fatigue or secondary traumatic stress with long-term exposure. Careful interpretation is necessary, given the study's comparatively low moral distress scores when compared to global benchmarks. Underreporting may have been caused by cultural factors like a reluctance to publicly express psychological distress, hierarchical workplace norms, and the normalisation of ethical adversity in settings with limited resources. Furthermore, the Moral Distress Scale Revised may not adequately capture the context-specific ethical challenges faced by medical professionals in Sri Lankan PICUs, as it was developed and validated primarily in high-income settings. These elements could account for a portion of the lower scores despite frequent exposure to morally challenging circumstances.

Notably, working hours per week demonstrated a statistically significant association with secondary traumatic stress ($p = 0.01$), showing similar findings from global burnout research where high workload, excessive hours, and limited rest predict emotional exhaustion and depersonalisation [18]. These findings reinforce the importance of workload management in preventing psychological strain. Workload is a major modifiable risk factor for psychological strain among PICU healthcare workers, as evidenced by the strong correlation between longer working hours and secondary traumatic stress. This research emphasises how crucial it is to control work hours and ensure

people get enough sleep to reduce secondary traumatic stress in high-intensity care settings.

Our study also reflects the impact of systemic limitations in Sri Lankan PICUs, such as resource scarcity and staffing constraints, which have been highlighted in global studies as factors that heighten moral distress [9]. As Fachini et al. [9] highlight, limited human and technological resources contribute to poor-quality care and increased moral distress, making this finding particularly relevant to low-resource environments. Convenience sampling was used due to limited PICU staffing, which may restrict generalisability and introduce selection bias.

Overall, although measured moral distress levels were mild, these findings should be interpreted cautiously, and psychological outcomes, which were generally favourable despite the presence of distress in ethically challenging contexts, underscore a vulnerable workforce. The lack of ethics training, inadequate debriefing opportunities, and heavy workloads indicate structural issues that need improvement. Strengthening institutional support, fostering open communication, and implementing ethics education could significantly mitigate moral distress and enhance professional well-being. The Moral Distress Scale's limitations, hierarchical workplace norms, or cultural underreporting of psychological distress could all contribute to the comparatively low moral distress scores compared to reports from other countries.

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Limitations

There are several limitations in this study. Here, we have used convenience sampling, which limits the study's generalisability. In addition, the tools we have used, such as ProQOL-5 and MDS-R, do not have sufficient sensitivity to cultural expressions. Participants with known anxiety or depressive disorders were excluded, which may lead to an underestimation of the distress levels. Self-report bias may be observed in the study, as the data are mainly based on participants' reports rather than objective measurements.

Conclusion

Healthcare professionals working in Sri Lankan paediatric intensive care units reported predominantly mild levels of moral distress, with generally favourable professional quality-of-life indicators. However, these findings should be interpreted cautiously, as low distress scores may not fully reflect the ethical and emotional challenges inherent in high-acuity care settings. The results highlight important gaps in institutional support, including limited access to ethics training, a lack of structured debriefing mechanisms, and the impact of heavy workloads. Addressing these organisational factors through targeted ethics education, regular debriefing opportunities, and improved workload management may help mitigate moral distress and support the well-being of this essential workforce.

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