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Relationship Between Quiet Quitting Attitudes and Moral Resilience Among Pediatric Nurses: A Cross-Sectional Study

Pediatri Hemşirelerinde Sessiz İstifa Tutumları ile Ahlaki Dayanıklılık Arasındaki İlişki: Kesitsel Bir Çalışma

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ABSTRACT

Introduction: In the context of the nursing workforce crisis that has deepened following the pandemic, the phenomenon of quiet quitting has come to the forefront, and understanding its relationship with moral resilience among pediatric nurses has gained increasing importance.

Aim: This study aimed to determine the relationship between quiet quitting attitudes and moral resilience among pediatric nurses.

Methods: This cross-sectional study was conducted with 202 pediatric nurses working in the pediatric units of private, public, university, and children's hospitals in Türkiye between September 2025 and April 2026. Data were collected using a "Descriptive Information Form, Quiet Quitting Attitude Scale, and Rushton Moral Resilience Scale". Descriptive statistics, student t-test, kruskal-wallis test, pearson correlation analysis, and multiple linear regression analysis were used to evaluate the data.

Results: A weak negative correlation was found between quiet quitting attitudes and moral resilience ($r = -0.277$; $p < 0.001$) among pediatric nurses. The regression model significantly predicted quiet quitting attitudes, explaining 12.4% of the variance ($R^2 = 0.124$; Adjusted $R^2 = 0.106$), with moral resilience emerging as the strongest predictor ($\beta = -0.26$; $p < 0.001$).

Conclusion: The relationship between moral resilience and reducing quiet quitting, a rising global problem among pediatric nurses, should be considered. In this regard, it is important to develop training and programs that support moral resilience, increase institutional satisfaction, and create healthy working environments for nurses.

Keywords: Burnout; moral resilience; nurses; pediatrics.

ÖZ

Giriş: Pandemi sonrası derinleşen hemşire işgücü krizi bağlamında sessiz istifa olgusu öne çıkarken, pediatri hemşireleri arasında ahlaki dayanıklılıkla ilişkisinin anlaşılması giderek önem kazanmaktadır.

Amaç: Bu araştırmada, pediatri hemşireleri arasında sessiz istifa tutumları ile ahlaki dayanıklılık arasındaki ilişkinin belirlenmesi amaçlanmıştır.

Yöntem: Bu kesitsel çalışma, Eylül 2025 ve Nisan 2026 tarihleri arasında Türkiye'deki özel, devlet, üniversite ve çocuk hastanelerinin pediatri servislerinde çalışan 202 pediatri hemşiresi ile yürütülmüştür. Veriler "Tanımlayıcı Bilgi Formu, Sessiz İstifa Tutum Ölçeği ve Rushton Ahlaki Dayanıklılık Ölçeği" aracılığıyla toplanmıştır. Verilerin değerlendirilmesinde "tanımlayıcı istatistikler, student t-testi, kruskal-wallis testi, pearson korelasyon analizi ve çoklu doğrusal regresyon analizi" kullanılmıştır.

Bulgular: Pediatri hemşirelerinin sesiz istifa tutumları ile ahlaki dayanıklıkları arasında ($r = -0,277$; $p < 0,001$) puanı arasında negatif yönde düşük düzeyde anlamlı ilişki olduğu tespit edilmiştir. Regresyon modeli, sessiz istifa tutumlarını anlamlı şekilde yordamış ($F = 6,968$; $p < 0,001$), varyansın %12,4'ünü açıklamış ($R^2 = 0,124$; Düzeltilmiş $R^2 = 0,106$) ve ahlaki dayanıklılık en güçlü yordayıcı olarak belirlenmiştir ($\beta = -0,26$; $p < 0,001$).

Sonuç: Pediatri hemşireleri arasında giderek artan küresel bir sorun olan sessiz istifa ile ahlaki dayanıklılık arasındaki ilişki dikkate alınmalıdır. Bu doğrultuda hemşirelerin, kurumsal memnuniyetin artırılması, sağlıklı çalışma ortamlarının oluşturulması ve ahlaki dayanıklılığı destekleyen eğitim ve programların geliştirilmesi önemlidir.

Anahtar Kelimeler: Ahlaki dayanıklılık; hemşireler; pediatri; tükenmişlik.

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Introduction

Global health systems are facing a deepening nursing workforce crisis, particularly in the aftermath of the pandemic (Abdullah & Bangcola, 2024). The World Health Organization (WHO) projects a shortage of approximately 10 million healthcare workers by 2030, emphasizing that a significant portion of this shortage will be in nursing (WHO, 2022). Evidence continues to accumulate that many nurses are internally withdrawing from the profession without actually leaving, due to insufficient nursing numbers, unmanageable workloads, burnout, and increasing ethical pressures (Haahr, Norlyk, Martinsen & Dreyer, 2020; Cranage & Foster, 2022; Iddrisu et al., 2023; Yi et al., 2024). In this context, quiet quitting stands out as a phenomenon increasingly discussed in the international nursing literature in recent years (Moisoglou, Katsiroumpa, Katsapi, Konstantakopoulou & Galanis, 2025; Yasin, Al-Hamad, Yasin & Kehyayan, 2025).

The profile of nurses who fulfill their duties completely but gradually withdraw their professional commitment and emotional investment constitutes the most prominent reflection of the phenomenon conceptualized in the literature as "quiet quitting" (Moisoglou et al., 2025; Yasin et al., 2025). The nursing profession is not only a technical practice profession but also a relationship profession requiring deep emotional labor (Doğan & Taşçı, 2019). The withdrawal of nurses' emotional engagement should be considered not merely an individual professional crisis, but a systemic issue that directly threatens patient safety and the quality of care. Moral resilience is defined as an individual's capacity to remain consistent with their values in ethically challenging situations and to maintain professional integrity despite moral distress (Lachman, 2016; Rushton, 2016). Some researchers conceptualize moral resilience as a protective buffer mechanism against quiet quitting, positioning it as a resource that enhances individuals' capacity to withstand challenging conditions (Antonsdottir et al., 2021; Galanis et al., 2024; Kovancı & Özbaş, 2023; Belli & Özçelik, 2026). On the other hand, from a critical perspective, it is argued that the discourse of moral resilience can shift the responsibility for structural transformation from the system to the nurse by reducing systemic or institutional problems to a matter of individual "resilience capacity" (Galanis et al., 2024; Bryant & Aggleton, 2025). Therefore, whether moral resilience is associated with reduced quiet quitting or instead reflects an individualized framing of structural problems remains a relevant question for future research.

Pediatric nursing is the clinical field where this debate is particularly intense. The unique emotional burden of caring for pediatric patients, the complex relational dynamics with their family, and the frequently encountered ethical dilemmas place pediatric nurses in a more vulnerable position in terms of moral distress and professional burnout compared to other clinical fields (Buckley, Berta, Cleverley, Medeiros & Widger, 2020; Miranda et al., 2024; Zhou et al., 2024). In contrast, research focusing on pediatric nursing and examining quiet quitting and moral resilience together is extremely limited. When the existing literature is examined, it appears that quiet quitting and moral resilience have largely been studied independently and that findings specific to the pediatric context remain limited. (Belli & Erçelik, 2026). The present study was conducted between September 2025 and April 2026 using an institutionally diverse sample of pediatric nurses employed in private hospitals, public hospitals, university hospitals, and children's hospitals. In this respect, the study aims to address the limitation regarding institutional diversity identified in previous research and to contribute to a more comprehensive evaluation of the relationship between quiet quitting and moral resilience among pediatric nurses working across different healthcare institutions. This gap makes it necessary, both scientifically and clinically, to systematically examine the relationship between these two variables in pediatric nurses.

Aim

This study aimed to determine the relationship between quiet quitting attitudes and moral resilience among pediatric nurses.

Research Questions

1. Do pediatric nurses' levels of quiet quitting attitudes and moral resilience scores differ according to sociodemographic characteristics?

2. What are the levels of quiet quitting attitudes and moral resilience scores of pediatric nurses?

3. Is there a statistically significant relationship between quiet quitting attitudes and moral resilience levels of pediatric nurses?

Method

Study Design

This study is descriptive and cross-sectional.

Study Setting and Sample

The population of this study comprises nurses working in pediatric units at private, public, university, and children's hospitals in Türkiye between September 2025 and April 2026. The sample for this study was calculated using multiple linear regression analysis (effect size $f^2 = 0.24$, significance level $\alpha = 0.05$, test power $(1-\beta) = 0.95$, minimum sample size 103), which is consistent with our study in the literature (Belli & Erçelik, 2026). Accordingly, the sample consisted of nurses who met the inclusion criteria for the study, and the study was conducted online with 202 pediatric nurses using convenience sampling. The inclusion criteria for the study were as follows: (a) a pediatric nurse working in the pediatric units of private, state, or university hospitals in Türkiye; (b) having internet access; (c) having Turkish communication skills; and (d) providing consent to participate in the study.

Data Collection Tools

The data was collected between September 2025 and April 2026 via an online survey form using the "Descriptive Information Form", the "Quiet Quitting Attitude Scale (QQAS)", and the "Rushton Moral Resilience Scale (RMRS)".

Descriptive Information Form: This form, developed by researchers in line with the literature, aims to determine the demographic characteristics of pediatric nurses and consists of a total of nine questions regarding gender, age, education level, marital status, having children, and professional experience (Lyu, Akkadechanunt, Soivong, Juntasopeepun & Chontawan, 2022; Spilg et al., 2022; Karaşin & Öztırak, 2023; Kovanci & Atlı Özbaş, 2023).

Quiet Quitting Attitude Scale (QQAS): QQAS was developed by Karaşin and Öztırak in 2023 to evaluate healthcare workers' attitudes towards quiet quitting (Karaşin & Öztırak, 2023). This scale consists

of 34 items, with only 27 being reverse-coded, and is structured as a 5 - point Likert-type scale. The scale comprises three sub-dimensions: personal beliefs, positive attitude, and perception of mobbing. The total Cronbach's alpha coefficient of the scale was 0.94; the Cronbach's alpha coefficients for the subscales were 0.95 for the personal beliefs subscale, 0.82 for the positive attitude subscale, and 0.65 for the perception of mobbing subscale. (Karaşin & Öztırak, 2023). In this study, the total scale score and the Cronbach's alpha coefficients of the subscales were determined as 0.94, 0.94, 0.61, and 0.85, respectively. The higher the score obtained from the scale, the greater the attitude of healthcare workers towards quiet quitting (Karaşin & Öztırak, 2023).

Rushton Moral Resilience Scale (RMRS): RMRS was developed by Heinze, Hanson, Holtz, Swoboda and Rushton (2021) to assess the moral resilience levels of health professionals, and its Turkish validity and reliability were established by Kovanci and Atli Özbaş (2023) (Heinze et al., 2021; Kovanci & Atli Özbaş, 2023). The scale consists of 17 items and 4 subscales: "response to moral challenges-5 items, personal integrity-3 items, relational integrity-5 items, and moral efficacy - 4 items." The RMRS total is 0.83, and the Cronbach alpha coefficients for the subscales are reported as: response to moral challenges = 0.75, personal integrity = 0.55, relational integrity = 0.77, and moral efficacy = 0.62 (Kovanci & Atli Özbaş, 2023). In this study, the Cronbach alpha coefficients are 0.75, 0.69, 0.56, 0.87, and 0.83, respectively. The scale is scored using a 4-point Likert-type structure, and all items except items 1, 3, 7, 9, 12, and 17 are reverse-scored (Heinze et al., 2021; Kovanci & Atli Özbaş, 2023). The scores range from 17 to 68, and higher scores indicate increased moral resilience among health professionals (Karaşin & Öztırak, 2023).

Ethical Considerations

Ethical approval for the study was obtained from a university's Ethics Committee for Medical and Scientific Research (No. 28.08.2025/835) and from the scale authors via email. Before the start of the study, the first section of the online questionnaire informed participants about the purpose of the study, the research team, the ethical approval number, and that participation was voluntary and that pediatric nurses could withdraw from the study at any time. In accordance with Google's privacy policy, informed consent was obtained from the nurses online, and the research process was conducted in "accordance with the principles of the Helsinki Declaration".

Data Collection

The data was collected online by the researchers between September 2025 and April 2026 using an online survey form created via Google Forms, following approval from the ethics committee, via various social media platforms such as Facebook, LinkedIn, Instagram, Telegram and WhatsApp. As a result, the issue of physical access for pediatric nurses working in different regions of Türkiye has been resolved, and remote access has been made available.

Data Analysis

The obtained data were analysed using the "SPSS (Statistical Package for Social Sciences) 22.0 software package". Skewness and kurtosis values ranging from -2 to +2 were used to assess the normality of the data distribution. Descriptive statistics, the Student's t-test for normally distributed binary groups, the Kruskal-Wallis test for non-normally distributed groups with more than two categories, and multiple linear regression analysis were used in the data analysis. In this study, the relationship between the total scores of QQAS and RMRS was evaluated using Pearson correlation analysis; correlation coefficients were classified as "0.00 - 0.10 (negligible); 0.10 - 0.39 (weak); 0.40 -0.69 (moderate); 0.70 - 0.89 (strong) and 0.90 - 1.00 (very strong)" (Schober, Boer & Schwarte, 2018). The results were evaluated at a "95% confidence interval and a statistical significance level of $p < 0.05$".

Results

Table 1 presents the demographic characteristics of pediatric nurses. The mean age of the pediatric nurses participating in the study was 33.26 ± 6.66 years, the mean professional experience was 11.01 ± 7.20 years, and the mean experience working in pediatric clinics was 7.36 ± 6.34 years.

Table 1: Characteristics of Pediatric Nurses (N = 202)

Variables	$\bar{X}^{\dagger}$ ± SD[‡]
Age	33.26 ± 6.66
Experience of Professional Work/Years	11.01 ± 7.20
Experience of Work in Pediatric Clinics/ Years	7.36 ± 6.34
	n[§] (%)[‖]
Gender	
Female	148 (73.3)
Male	54 (26.7)
Education Level	
Health vocational high school	30 (14.9)
Associate degree	21 (10.4)
Bachelor's degree	98 (48.5)
Postgraduate	53 (26.2)
Marital Status	
Married	98 (48.5)
Single	104 (51.5)
Having Children	
Yes	106 (52.5)
No	96 (47.5)
Sector of Employment	
Private hospital	17 (8.4)
State hospital	73 (36.1)
University hospital	96 (47.5)
Children's hospital	16 (7.9)
Department	
Pediatric unit	41 (20.3)
Neonatal intensive care unit	43 (21.3)
Pediatric intensive care unit	35 (17.3)
Pediatric emergency	34 (16.8)
Pediatric subspecialty units (infectious diseases, cardiology, endocrinology etc.)	30 (14.9)
Pediatric hematology and oncology	19 (9.4)

[†]$\bar{X}$: Mean; [‡]SD: Standard Deviation; [§]n: Number; [‖]%: Percentage

Table 2: Distribution of Mean Total and Subscale Scores of RMRS and QQAS (N = 202)

	Minimum - Maximum	$\bar{X}^{\dagger} \pm SD^{\ddagger}$
QQAS[§] Total	49 - 163	119.70 ± 28.21
Personal beliefs	31 - 117	83.29 ± 22.34
Positive attitude	6 - 25	17.03 ± 4.79
Perception of mobbing	6 - 25	19.38 ± 5.13
RMRS[‖] Total	17 - 62	43.99 ± 7.44
Response to moral challenges	5 - 20	9.44 ± 3.08
Personal integrity	3 - 12	8.38 ± 2.20
Relational integrity	5 - 20	13.15 ± 4.37
Moral efficacy	4 - 16	13.01 ± 2.80

[†]$\bar{X}$: Mean; [‡]SD: Standard Deviation; [§]QQAS: Quiet Quitting Attitude Scale; [‖]RMRS: Rushton Moral Resilience Scale

73.3% of the pediatric nurses were female, 48.5% held a bachelor's degree, 51.5% were single, and 52.5% had children. 47.5% of the nurses worked in a university hospital, and 21.3% worked in a neonatal intensive care unit.

Table 2 shows the mean distributions of total and subscale scores of QQAS and RMRS. The mean QQAS total score of pediatric nurses was 119.70 ± 28.21, the mean personal beliefs score was 83.29 ± 22.34, the mean positive attitude score was 17.03 ± 4.79, and the mean perception of mobbing score was 19.38 ± 5.13. The mean RMRS total score of pediatric nurses participating in this study was 43.99 ± 7.44, the mean response to moral challenges score was 9.44 ± 3.08, the mean personal integrity score was 8.38 ± 2.20, the mean relational integrity score was 13.15 ± 4.37, and the mean moral efficacy score was 13.01 ± 2.80.

Table 3 compares the mean total scores of QQAS and RMRS for pediatric nurses based on their demographic characteristics. Male nurses had a higher mean total QQAS score (t = -2.352, p = 0.020), while female nurses had a higher mean total RMRS score (t = 2.044, p = 0.044), and this difference was statistically significant. A statistically significant difference was also found between education level and the mean total QQAS score, with nurses who graduated from health vocational high schools having a higher mean score (KW = 12.784, p = 0.005). The results of the post hoc analysis revealed that the difference in question was between graduates of healthcare vocational schools and those with bachelor's and postgraduate degrees. Nurses who were married had a higher mean total RMRS score (t = 2.441, p = 0.016), and this difference was statistically significant. A statistically significant difference was found between the sector of employment variable and the mean total QQAS score (KW = 11.234, p = 0.011), with nurses working in university hospitals having a higher mean score. According to the post hoc analysis conducted, it was determined that there is a difference between nurses working in state hospitals and those working in university hospitals. However, no statistically significant relationship was found between the total QQAS score and marital status, having children, and the department; nor between the total RMRS score and education level, having children, the institution worked in, and the unit worked in (p > 0.05).

Table 3: Examination of Pediatric Nurses' Descriptive Characteristics According to The Mean Total Scores of QQAS and RMRS (N = 202)

Variables	QQAS[§] Total $\bar{X}^{\dagger} \pm SD^{\ddagger}$	RMRS[‖] Total $\bar{X}^{\dagger} \pm SD^{\ddagger}$
Gender		
Female	116.91 ± 27.83	44.72 ± 6.65
Male	127.35 ± 8.09	41.98 ± 9.02
t-test/p	**-2.352 / 0.020***	**2.044 / 0.044***
Education Level		
Health vocational high school	135.46 ± 18.20	44.53 ± 6.65
Associate degree	117.95 ± 29.56	43.90 ± 7.17
Bachelor's degree	117.31 ± 30.62	43.17 ± 8.16
Postgraduate	115.90 ± 25.24	45.24 ± 6.49
KW[††] test/p	**12.784 / 0.005***	3.451 / 0.327
Marital Status		
Married	118.96 ± 28.93	45.29 ± 7.32
Single	120.40 ± 27.64	42.76 ± 7.37
t-test/p	-0.360 / 0.719	**2.441 / 0.016***
Having Children		
Yes	118.83 ± 28.88	44.00 ± 7.03
No	120.67 ± 27.57	43.98 ± 7.90
t-test/p	-0.464 / 0.643	0.010 / 0.992
Sector of Employment		
Private hospital	122.11 ± 24.64	45.41 ± 8.42
State hospital	111.58 ± 29.14	44.16 ± 7.10
University hospital	125.89 ± 26.98	43.41± 7.67
Children's hospital	117.06 ± 27.44	45.18 ± 6.72
KW test/p	**11.234 / 0.011***	1.779 / 0.620
Department		
Pediatric unit	119.68 ± 28.66	43.39 ± 7.01
Neonatal intensive care unit	113.23 ± 27.95	46.48 ± 7.91
Pediatric intensive care unit	123.11 ± 29.33	43.71 ± 7.61
Pediatric emergency	120.76 ± 29.39	42.08 ± 7.29
Pediatric subspecialty units (infectious diseases, cardiology, endocrinology etc.)	127.33 ± 22.67	44.66 ± 6.56
Pediatric hematology and oncology	114.21 ± 30.82	42.52 ± 7.79
KW test/p	6.425 / 0.267	6.749 / 0.240

[†]$\bar{X}$: Mean; [‡]SD: Standard Deviation; [§]QQAS: Quiet Quitting Attitude Scale; [‖]RMRS: Rushton Moral Resilience Scale; [††]KW: Kruskal-wallis test; *p < 0.05

The relation between the quiet quitting attitude and moral resilience among pediatric nurses is presented in Table 4. A low-level, statistically significant negative correlation was found between paediatric nurses' quiet quitting attitude and their moral resilience score (r = -0.277, p < 0.001) among pediatric nurses. In other words, as the level of moral resilience decreased among pediatric nurses, their level of quiet quitting attitude increased.

In this study, a multiple linear regression model was constructed using gender, education level, sector of employment, and total moral resilience score to determine the variables predicting the total quiet

Table 4: Correlation between Quiet Quitting Attitude and Moral Resilience in Pediatric Nurse

Variables	Quiet Quitting Attitude	Moral Resilience
Quiet Quitting Attitude	-	-0.277**/ p < 0.001**
Moral Resilience	-0.277**/ p < 0.001**	-

†p: Significance Level; **p < 0.001.

quitting attitude score. The result was an AdjR² of 0.106. This finding indicates that all variables included in the model together explain 10.6% of the variation in the total quiet quitting attitude score (R^2 : 0.124, AdjR^2 : 0.106, F = 6.968, p < 0.001). In the model, education level and total moral resilience score were identified as significant predictors of quiet quitting attitude (p < 0.001) (Table 5).

Discussion

This study provides information on the quiet quitting attitude and moral resilience among pediatric nurses. Given the limited number of studies in the literature examining these aspects of pediatric nurses, this study will make a valuable contribution (Belli & Erçelik, 2026). In this study, it was determined that female pediatric nurses had higher QQAS scores and male nurses had higher RMRS scores, and gender was found to be a determining demographic variable for both quiet quitting tendency and moral resilience. A study conducted with healthcare workers in Türkiye indicated that male healthcare workers had lower rates of quiet quitting compared to female healthcare workers (Karalinç, 2024). This finding parallels the higher quiet quitting attitudes observed among female pediatric nurses in the present study, suggesting that gender may be associated with quiet quitting. Female nurses face a greater emotional labour burden and structural barriers (Galanis et al., 2024; Geng et al., 2026). Although male nurses remain a minority within the predominantly female nursing profession, they appear to hold advantages in terms of career opportunities and promotion, which may further contribute to higher quiet quitting attitudes among their female colleagues (Galanis et al., 2024; Geng et al., 2026). In the literature, studies that evaluated moral resilience according to the gender variable, similar to this study, found that male participants had higher levels of moral resilience (Lyu et al., 2022; Spilg et al., 2022; Kovanci & Atlı Özbaş, 2023). This consistency between previous findings and the current study which found that male pediatric nurses had higher RMRS scores suggests that gender may play a role in shaping moral resilience and that this pattern emerges similarly across different cultural and professional contexts. Furthermore, since the percentage of male nurses in this study was limited to 26.7%, it is recommended that studies including a higher percentage of male nurses be conducted to more robustly examine differences between genders.

One of the key findings of this study is that married nurses have higher RMRS scores. This finding is thought to be related to the coping skills that married individuals develop in balancing family and work life. A study conducted by Geng et al. (2026) reported that marital status increased sensitivity to workplace support and had a moderating effect on quiet quitting behaviours (Geng et al., 2026). Similarly, Chen, Zhang, Zheng, Hong and Zhang (2024) reported that married nurses had higher levels of moral resilience compared to single or separated nurses (Chen et al., 2024). The similarity between previous findings and the results of the present study suggests that marital status may play a role in shaping moral resilience among pediatric nurses. Accordingly, it is thought that marital relationships can be considered an important source of social support that supports nurses' capacity to cope with stress and their competence to deal with ethical challenges (Chen et al., 2024).

This study determined that pediatric nurses who graduated from health vocational high school had higher levels of quiet quitting attitudes. Similarly, a study conducted with healthcare workers reported that the majority of participants were high school graduates and that

Table 5. Relationship Between the Quiet Quitting Attitude and Some Variables

Factors Associated With Quiet Quitting Attitude†	QQAS†† Total					
	β¹ (95% CI‡)	SE	β2	t	p	VIF§
Constant	170.036 (144.658, 195.415)	12.869		13.213	**< 0.001***	
Gender	7.600 (-0.965, 16.165)	4.343	0.119	1.750	0.082	1.049
Education Level	-11.732 (-20.447, -3.018)	4.419	-0.181	-2.655	**0.009***	1.046
Institution of Employment	0.006 (-10.357, 10.370)	5.255	0.000	0.001	0.999	1.071
RMRS‖ Total	-0.991 (-1.497, -0.485)	0.257	-0.261	-3.860	**< 0.001***	1.031
F: 6.968 R: 0.325 R^2: 0.124 AdjR^2: 0.106 p < 0.001						

†Multiple Linear Regression Analysis; ‡CI: Confidence Interval; §VIF: Variance Inflation Factor; ‖RMRS: Rushton Moral Resilience Scale; ††QQAS: Quiet Quitting Attitude Scale; *p < 0.05

there was a significant difference in quiet quitting attitudes according to education level (Karalinç, 2024). Koçak et al. (2026) reported that the tendency to resign increases as the level of education among healthcare workers decreases (Koçak et al., 2026). These findings are consistent with the results of the present study and suggest that educational level may be an important factor shaping nurses' attitudes toward quiet quitting. Higher levels of education may contribute to the development of critical thinking, problem-solving skills, ethical awareness, professional competence, and coping capacity (Geng et al., 2026; Koçak et al., 2026), which may in turn reduce the likelihood of quiet quitting attitudes.

Another important finding of this study is that pediatric nurses working in university hospitals have higher rates of quiet quitting attitudes. University hospitals are highly complex organisations characterised by the concurrent provision of diverse services, heavy workloads, shortages of supplies, long working hours, excessive shift lengths, low pay, staff shortages, and staff being forced to perform tasks outside their professional roles (Özdaş & Kızılkaya, 2021; Gün, Balsak & Ayhan, 2025; Belli & Erçelik, 2026). A study conducted with healthcare workers employed at university hospitals in Türkiye found that staff turnover rates were moderate and that quality of working life and work-related emotional exhaustion had an impact on quiet quitting (Gökkaya, 2024). In line with these findings, in order to reduce the rate of quiet quitting among pediatric nurses, the problems raised by nurses should be prioritised and addressed according to their importance. The consistency between these findings and the results of the present study suggests that working conditions and institutions characterised in university hospitals may play an important role in the development of quiet quitting attitudes among pediatric nurses. Furthermore, enhancing institutional satisfaction, implementing appropriate shift arrangements that allow for rest, strengthening communication, and providing training and professional development opportunities are considered priority intervention areas that support nurse well-being (Özdaş & Kızılkaya, 2021; Gün et al., 2025; Belli & Erçelik, 2026; Geng et al., 2026; Koçak et al., 2026).

Moral resilience, which enhances job commitment and reduces burnout by strengthening the capacity to cope with ethical stress in healthcare professionals, is one of the important individual factors influencing quiet quitting behaviour (Özdaş & Kızılkaya, 2021; Galanis et al., 2024; Mutlu & Mat, 2025; Gün et al., 2025; Belli & Erçelik, 2026; Geng et al., 2026; Koçak et al., 2026). Similarly, studies in the literature also show that moral resilience is associated with lower quiet quitting levels among nurses (Galanis et al., 2024; Mutlu & Mat, 2025; Belli & Erçelik, 2026). The consistency of these findings with the present study suggests that moral resilience may be an important factor associated with lower quiet quitting attitudes among pediatric nurses. However, the regression model constructed using gender, education level, sector of employment, and total moral resilience score explained only a modest proportion of the variance in quiet quitting attitudes among pediatric nurses.Therefore, while moral resilience appears to be a meaningful correlate of quiet quitting attitudes, it should not be regarded as the primary or sole determinant of this behavior, and the present findings should be interpreted with caution. Given these findings, training programs aimed at increasing moral resilience, creating healthy work environments, developing institution-specific strategies, and planning initiatives that strengthen emotional management skills are important, and qualitative and quantitative studies are needed to better understand the role of moral resilience in quiet quitting among pediatric nurses.

The inclusion of participants via online platforms and on a voluntary basis is an important consideration when interpreting the findings of this study. Given that nurses who have a greater interest in quiet quitting or moral resilience, or who hold more pronounced attitudes regarding these issues, may have been more willing to participate, it should not be overlooked that the strength of the relationship between moral resilience and quiet quitting observed in this study may differ from the true relationship in the wider population of paediatric nurses. Similarly, the potential under-representation of nurses with limited time availability or restricted access to social media during working hours may limit the extent to which the findings reflect the general population of paediatric nurses in Türkiye.

Limitations of the Study

The fact that the study was conducted using a cross-sectional design, that data were collected exclusively online from paediatric nurses in Türkiye through social media and online platforms and were therefore limited to nurses with internet access, that the findings were based on self-reported data, and that the results can only be generalised to the study sample are among the limitations of this study. In addition, recruitment through social media and online platforms may have resulted in the over-representation of nurses who actively use digital communication channels or were more motivated to participate in the study, while nurses with limited engagement in social media platforms may have been under-represented. According to the literature, Cronbach's alpha coefficients between 0.40 and 0.59 indicate low reliability, coefficients between 0.60 and 0.79 indicate acceptable reliability, and coefficients of 0.80 or higher indicate high reliability (Kalaycı, 2010; Tavşancıl, 2010). Although the Cronbach's alpha coefficient of the personal integrity subscale was relatively low (α = 0.56), similar variability in the reliability coefficients of the RMRS subscales was also reported in the Turkish adaptation study, where alpha values ranged from 0.55 to 0.77 (Kovanci & Atlı Özbaş, 2023). Therefore, the relatively low reliability observed for this subscale may reflect the psychometric characteristics of the subscale itself rather than a limitation specific to the present sample. Furthermore, the analyses and main findings of this study, including the regression model, were based on the total RMRS score, which demonstrated acceptable internal consistency (α = 0.75). Despite these limitations, the fact that this study addresses the concept of quiet quitting, which the nursing profession has faced in recent years, within the context of pediatric nursing constitutes a significant strength of the study.

Conclusion

In conclusion, this study demonstrates that the quiet quitting attitude experienced by the nursing profession globally is a significant problem among pediatric nurses. The findings of this study revealed that pediatric nurses' quiet quitting attitude differed according to gender, education level, and sector of employment, while their moral resilience differed according to gender and marital status. Furthermore, it has been determined that those who graduated from health vocational high schools, male nurses, and those working in university hospitals may be at greater risk of quiet quitting. Accordingly, considering the relationship observed between moral resilience and quiet quitting

attitudes in this study, it is thought that this behavior should not be addressed solely as an individual problem. Especially for at-risk groups, strengthening supportive strategies and reducing stress factors, taking into account institutional characteristics, will contribute to maintaining nurses' professional commitment. Future studies need to evaluate the role of increasing moral resilience in reducing quiet quitting attitudes, considering the stress and burnout levels and coping strategies of pediatric nurses.

Ethical Considerations: Ethical approval for this study was obtained from the Akdeniz University Medical Scientific Research Ethics Committee (Date: 28.08.2025 and Number: 835).

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