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Intensive care nurses' lived experience of altruism and sacrifices during the Covid-19 pandemic: A phenomenological study

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Abstract

Aim: The aim of this study was to understand the lived experience of altruism and sacrifices among Swedish nurses working in intensive care units (ICU) during the COVID-19 pandemic.

Design: This was a descriptive phenomenological study.

Methods: The study was conducted between June 2020 and March 2021 and included 20 nurses who were directly involved in the ICU care of COVID-19 patients in Sweden during the pandemic. The text transcripts were analysed using Malterud's Systematic Text Condensation.

Findings: The analysis revealed four themes. *The work situation changed from 1 day to another*—the nurses were brutally confronted with a new and highly demanding situation. *Adapting to the chaotic situation*—despite fear, anguish and exhaustion, the nurses adapted to the new premises. They shouldered the moral responsibility and responded to the needs of the patients and the health care system since they had the competence. *Being confronted with ethical and moral challenges*—the nurses were overwhelmed by feelings of helplessness and inadequacy because despite how hard they worked, they were still unable to provide care with dignity and of acceptable quality. *The importance of supporting each other*—collegiality was fundamental to the nurses' ability to cope with the situation.

Conclusions: Taken together, being exposed to a constantly changing situation, facing the anguish and misery of patients, families, and colleagues, and being confronted with a conflict between the moral obligation to provide care of high quality and the possibility to fulfil this commitment resulted in suffering among the nurses. Collegial back-up and a supportive culture within the caring team were important for the nurses' endurance.

No patient or Public Contribution. However, study findings will be shared with health care professionals and key stakeholders.

Impact: The study contributes an understanding of nurses' lived experience of working during the COVID-19 pandemic and highlights the importance of protecting and preparing nurses and nursing organisation for potential future crises.

KEYWORDS
COVID-19, dignity, lived experience, moral stress, nursing care, nursing science, qualitative, suffering

1 | INTRODUCTION

At the beginning of 2020, the rapid spread of the coronavirus caused a major strain on health care systems across Europe. Extraordinary measures were taken by health care authorities to cope with the increasing number of severely ill patients who needed ventilator support, and the organization in and around intensive care units (ICU) was particularly challenged. High mortality rates and the virus itself unpredictability exerted significant pressure on health care and their professionals (Chemali et al., 2022) since working close to the patient increased the risk of one's own infection (Nguyen et al., 2020). Globally, the COVID-19 pandemic has varied in severity, time and number of infected patients, but the response to this event remained rather similar among countries. In Sweden, the first pandemic wave started in March 2020, with a few cases to begin with, but the number of severely ill patients increased almost exponentially (Ministry of Health and Social Affairs, 2022). The health care professionals in Sweden worked long shifts (12.5 h/day) for an extended period of time to meet the increasing need for intensive care. Nurses and physicians from other departments and specialities were transferred to the ICUs to help with patient care. Some nurses were voluntarily transferred while others had fewer choice. Worldwide, health care professionals are used to encounter crises, but the COVID -19 pandemic challenged their performance and ability to provide safe care for a long time during extremely stressful conditions.

2 | BACKGROUND

Altruism is the moral practice of concern for other human beings' well-being and is historically a part of the nursing profession (Martinsen, 2000). Altruism is one of the professional values that reflects the standard of nursing care, with a concern for the welfare of others and a willingness to make sacrifices for, and prioritize, the needs of others (van der Wath & van Wyk, 2020). A pre-pandemic study about altruism in modern health care indicated that nurses were not willing to fully respond to the ethical demand of patients. In this context, the question was raised whether nurses would fulfil their obligations to health care in case of a disaster, if their personal safety would be threatened (Slettmyr et al., 2017). However, during the initial phase of the COVID-19 pandemic, nurses' dedication and willingness seemed to increase, contrary to what was feared (Slettmyr et al., 2022; Wu et al., 2020). These spontaneous altruistic actions need to be understood since the nurses' willingness to provide health care during crises is essential to maintain an acceptable standard of care (Whear et al., 2021).

So far, the existing literature on nurses' experiences of working during the COVID-19 pandemic has predominantly focused on health care workers' mental health (da Silva & Barbosa, 2021) or factors such as professional identity, career choices, work-life balance and work routines (Chemali et al., 2022). According to Chemali et al. (2022) and da Silva and Barbosa (2021) the high workload, the experiences of many deaths, and the lack of personal protective equipment were factors that induced feelings of anxiety, irritability and anguish when caring for patients. Negative emotions seemed to dominate the initial phase and feelings of guilt, blame and helplessness were expressed in relation to the experienced low-quality care that was delivered (Chemali et al., 2022; da Silva & Barbosa, 2021). Interpersonal relations with family, colleagues and patients were also affected and the health care workers adjusted to the extreme situation by e.g., moving out to protect their families from being infected by the virus, and could thereby only provide limited emotional support to family and friends. Institutional unpreparedness, poor communication skills and lack of support were considered to be problematic issues, as were contradictive and confusing guidelines. For example, the visitation restrictions did not take the individual cases into consideration which in turn created challenges for the nurses in the encounters with patients and families (Chemali et al., 2022). However, as time passed, a purpose, motivation and a sense of meaningfulness occurred. In addition, a kind of hero status arouse, that induced a positive feeling of being recognized and appreciated, but also, indirectly, pressured the nurses to work even harder (Chemali et al., 2022; da Silva & Barbosa, 2021).

Although multiple studies have been published regarding health care professionals' experiences of the COVID-19 pandemic, few have explored the lived experience of nurses in relation to altruism and moral obligations during a crisis. In undertaking this study, our intention was to contribute to illuminate issues that may be helpful for understanding the sacrifices made by the individual nurses during the COVID-19 pandemic, which may be of interest when protecting and preparing nurses and the nursing organization for future crises.

3 | THE STUDY

3.1 | Aim

The aim of this study was to understand the lived experience of altruism and sacrifices among Swedish nurses working in intensive care units (ICU) during the COVID-19 pandemic.

3.2 | Design

This descriptive phenomenological study of lived experiences was conducted with a nursing science perspective. Phenomenology seeks to understand the essence of human experiences and how the individual's lifeworld influences these experiences (Malterud, 2012). By allowing nurses to identify meaningful sequences of their experiences, a deeper understanding of the experiences' meaning, and context, was obtained. This method was developed by Giorgi, inspired by Husserl's philosophy and further developed by Malterud (2012).

3.3 | Participants

The study involved recruiting registered nurses, who specialized in intensive or anaesthesia care, or both intensive care and anaesthesia, directly involved in COVID-19 patient ICU care. All of them had a previous (pre-pandemic) experience in ICU care, some in adult ICUs and others from paediatric units. The nurses were recruited from ICUs in two urban hospitals in Stockholm, Sweden. A purposive sampling technique was used. Nurses who chose not to participate in clinical work during the pandemic were excluded from the study.

The informants were invited to the study by e-mail, where full study information was provided. Nurses who were willing to participate contacted the researchers (ASl & CM) who arranged for the interview.

3.4 | Data collection

Individual interviews were conducted between June 2020 and March 2021. Four interviews were held after the first wave of the pandemic (June–July 2020), 11 in the initial phase of the second wave (October to November 2020) and 5 during the end of the third wave (February to March 2021). Data collection was paused during summer 2020, because the nurses were either on vacation or had to work clinically in the ICU with little time for participating in interviews.

Data were collected using a semi-structured interview guide developed by the research team, based on academic and clinical preunderstanding of the phenomena (File S1). Four pilot interviews were conducted to test the interview guide. No changes to the guide were found necessary, and the interviews were included in the analysis. The interviews were conducted by three researchers (ASl, CM and ÅH) and were audio-recorded. Data collection ceased when no new information appeared in the interviews. According to Malterud et al. (2016) concept of information power, "*the more information a sample holds, relevant for the actual study, the lower amount of participants is needed*" (p. 1759). Given the aim of the study, the rich experience shared by the study informants and the phenomenological concept with an altruistic perspective used to interpret the results, inclusion of 20 nurse was considered acceptable to obtain information power (Malterud et al., 2016).

3.5 | Ethical considerations

This study was approved by the Ethical Review Authority in Stockholm (Document ID: 2020-02699) and conformed to the principles described in the Declaration of Helsinki. All informants were individually informed about the study and the fact that they could withdraw at any time. Full study information was provided in writing, and all informants gave written informed consent before the interview. Confidentiality and participant anonymity regarding the interview transcriptions and quotations used in this analysis were guaranteed.

3.6 | Data analysis

The analysis was conducted following Malterud's Systematic Text Condensation (2012). All authors read all interviews, one interview text at a time, and formed the first common understanding of the content. Thereafter, two of the researchers (ASl & ASc) conducted a structural analysis identifying meaning units relevant to the aim of the study and decontextualized the text. The meaning units were coded, further classified and sorted in a flexible dynamic reflection regarding commonalities and differences. The decontextualized units and codes were arranged into themes and subthemes which were discussed and reorganized between the authors, formulating preliminary subthemes (Table 1). An initial condensation in first-person format was systematically formulated (together with a suitable quote that illustrated the text condensation) to form subthemes. Finally, an analytic text verbalized the reconceptualized themes from a third-person perspective.

3.7 | Rigour

Throughout the study, methodological rigour and trustworthiness were ensured attained by using qualitative concepts of relevance such as reflexivity and transferability as described by Malterud (2001). The initial reading of the data, researcher triangulation and continuous discussion and questioning of the findings contributed to creating a common understanding in the analytic phase. In the initial step of the analysis, the researchers discussed each individual interview in groups, to bridle their pre-understanding and

TABLE 1 Examples of structural analysis

Meaning units	Condensed meaning units	Themes
Being confined in the small patient rooms made everything more difficult (….) it was hot, sweaty and it (*the protection mask*) was uncomfortable and scratchy. And you had to plan for when and what to drink, and be aware of not drinking too much, because if you did, you had to exit the room to use the bathroom…. (Nurse 3)	What I had to endure	The work situation changed from one day to another
I stood like this and watched the situation and thought "This is the worst (*thing*) I have ever seen (…) bandages soaked in blood on the floor, piles of rubbish, endotracheal tube occlusions, emergency calls, people running, it felt like "This is not for real, this cannot be true." (Nurse 10)	Standing in the middle of a disaster	
… you were full of adrenaline, and sort of expected the situation to become worse. So, I just went into a…something like…well, you know, the only thing I did was to work… (Nurse 4)	Like being in a "bubble" of work	Adapting to the chaotic situation
Now I could bike to work, I got some fresh air and had the time to contemplate what I had been through. (Nurse 6)	Created some breathing space. To cope with the situation	
…the priorities have been…burdensome to cope with. But to make correct prioritisations have been rather straight forward. Still, I have difficulties to oversee a bed that is not clean or a dirty pillowcase. That is extremely uncomfortable for me. (Nurse 11)	Giving low priority to nursing care was burdensome	Being confronted with ethical and moral challenges
… it is strange to see 10 to 12 patients in prone position laying in rows (…) …the patients became bodies and no longer human beings… (Nurse 14)	Care provided in a depersonalized context	
In solidarity with your colleagues, you stand up for each other. Especially in a situation like this. They are most important; they are always most important. (Nurse 8)	Together as a unity	The importance of supporting each other
You share the same experiences, you share it with someone who has been there themselves, walked in the same shoes (….). You are not alone in this, but you are just one person in a larger group of people who have similar experiences, I think that was what mattered most, really…. (Nurse 9)	Your colleagues are the ultimate support	

to be able to more clearly focus on the nurses' perspectives of the phenomena (Malterud, 2012). The research group had experience in ethics, psycho-traumatology and disaster nursing, of whom some also had clinical experience in intensive care nursing (though not during the pandemic). In the discussion and formulation of conclusions, the differing academic backgrounds of the researchers contributed to deepen the understanding.

To strengthen the credibility of the study, the less experienced researchers (a doctoral student and two ICU nurses with a masters' degree), were supported by three senior post-doctoral supervisors. The study was prepared in accordance with the consolidated criteria for reporting qualitative research, COREQ (Tong et al., 2007) (File S2).

4 | FINDINGS

4.1 | Sample characterization

Of the 27 nurses who were invited to participate, 7 declined or did not reply to the e-mail, and 20 nurses, 15 women and 5 men, were included in this study. Further details of the characteristics of participants can be found in Table 2.

TABLE 2 Description of the included informants

Characteristics	
Total number	20
Age, years median (min–max)	44 (27–64)
Sex (number)	
Men	5
Women	15
ICU work experience	
Years, median (min–max)	11 (1–38)
Specialized in	
Intensive care	17
Anaesthesia	2
Intensive care and Anaesthesia	1
Pre-pandemic employment	
Adult ICU	14
Paediatric ICU	6

The interviews were 30–100 min in duration and held in a private room, one to one, at the hospital ($n = 15$), by telephone ($n = 1$) or as a digital web interview ($n = 4$) via Zoom (only the sound was audio-recorded). Six interviews were transcribed verbatim by one

researcher (CM) and the rest were transcribed by a transcription agency.

4.2 | Theme one: The work situation changed from one day to another

The nurses were aware that a pandemic was a possible scenario they would have to deal with. Still, they perceived a paucity of mental preparedness for the magnitude of what such a situation would imply. Media reports at the beginning of the pandemic indicated what would come, and they dreaded what they would be confronted with.

> … on the Italian television you had seen how they (the patients) were placed in rows, side by side. It felt like a big black cloud just appeared above you. (Nurse 1)

The nurses understood that they were heading into a new work situation, and the transition was exceptionally rapid, almost from one day to another. They had to form a new frontline organization, move into larger facilities, expand their work shifts and collaborate with colleagues with limited ICU competence to be able to meet the challenges of the galloping new disease. The situation was experienced as surreal and turbulent. The nurses feared that the upcoming situation would be highly demanding.

> … a new, unfamiliar situation that would demand that you gave more of yourself than you had ever done before. (Nurse 3)

The workplace was perceived as a catastrophe site, almost like a war zone, or as:

> …a nasty episode of Fawlty Towers, but in real life. (Nurse 8)

Patients "crashed" unexpectedly, and emergency situations occurred to an extent never previously experienced.

Several work assignments that normally were outside the nurses' competence and responsibility were now demanded. Somewhat reluctantly, the nurses shouldered the increased responsibility because they felt that they had to ensure and maintain the safety of the patients. Those who had ICU competence had to take the lead and cover for less experienced, or unexperienced, nurses and physicians. This increased the already hard-working ICU nurses' burden even further. Occasionally, when they worked with an ICU-competent colleague, they experienced enormous relief.

Worry about catching the contagious virus was constantly in the mind of the nurses. In every encounter with a severely ill patient, the nurses were reminded of that the virus could be deadly. At the same time, working with personal protection equipment was perceived as physically exhausting. The equipment did not fit properly; it chafed and hurt.

> I recall a work shift where I, after six hours' work, could not take it any longer but did not have the energy to even remove my protection gear […], I sat down on the floor for a 2-minute rest […]. I could not stand upright any longer. Then, I had to get up and go back to work again. I felt despair, I could not do this, but I had no other choice… (Nurse 7)

To be confined in a room with an infectious patient, in full protection gear, not knowing when they were to be let out, was perceived as almost claustrophobic.

The nurses' lives circulated around only work and sleep. They felt that the employer had total power over them. They worked at over full capacity for a long time, and eventually, their bodies reacted with exhaustion, lack of energy and emotional numbness. Some nurses suffered from insomnia, fatigue-related eating difficulties, absence of menstruation and/or symptoms of depression. The situation was also straining on family life. Not being able, or not having the strength, to take care of their children when they were off duty, created a sense of guilt.

4.3 | Theme two: Adapting to the chaotic situation

Even if the situation was frightening, the nurses perceived that they had a moral obligation to respond to the needs of patients and the health care system.

> …this is a risk you take when you become a nurse, you must prioritize others before yourself. (Nurse 12)

Because the nurses possessed the knowledge, and experience, they felt they had a responsibility to care for the severely ill patients during the pandemic. The option, not to provide care, was considered to be selfish, unthinkable and a decision too painful to live with. The extreme situation required that the nurses accepted the situation and continued to work hard. They perceived that they were isolated in "a bubble" of work. The nurses felt high on adrenaline, rolled up their sleeves and were prepared to work hard. There was no time to think or reflect, and many nurses had vague memories of the initial period of the pandemic. The extreme situation required new, creative developments, with compromises and makeshift health technologies and pharmaceutical solutions.

> Do we have anything that corresponds to this [a sedative drug]? Yes, but this is labelled with a picture of a cat. Does it have similar content [as the intended drug]? Yes. Okay, then let's use it. (Nurse 8)

The nurses had to be flexible and were challenged to use their whole intellectual capacity to resolve difficult situations that continuously appeared. Some expressed that they grew in their professional role but also on an individual level. They felt that they had created history,

which made them feel important. However, over time, the nurses' energy and enthusiasm diminished, and feelings of hopelessness and tiredness soon appeared.

Each day, they confronted their fear of going to work, but, still, they went dutifully and did the best they could. Some nurses described how they tried to live day by day and accept the situation as it was.

> …I can rest in that I could not have done more than this…Every day, I have done my best and even extra. (Nurse 11)

Other ways to cope with the situation included keeping an emotional distance from the patients or to daydream about changing careers. Strolling in the forest or engaging in embroidery were other ways of creating breathing space in everyday life. As a last resort to rest and to protect themselves from being totally drained of energy, the nurses called in sick.

4.4 | Theme three: Being confronted with ethical and moral challenges

The nurses described how they ran between patients and did not know what, whom and how to prioritize. They rushed around with a feeling that they were drowning and unable to control the situation. They did not have time to think clearly.

> I drown in all work assignments, all of equal importance. (Nurse 10)

The nurses experienced that they lacked prerequisites to manage the extreme workload. They felt that whatever they did, it was not enough. There was an endless shortness of human resources, which created persistent distress among the nurses.

> Then the feeling returns, whatever we do, they just die… (Nurse 12)

The nurses realized that there was a limit to what they could do, but, still, they blamed themselves for not doing more. In the initial chaotic situation, life-saving procedures had to be prioritized and there was no time for nursing care, such as hygiene or preventing decubitus. They understood and accepted this prioritization and tried to do their best under the circumstances. However, they had to abandon their basic values of care and experienced that the safety of the patients could not be guaranteed. The nurses perceived that the quality of health care was reduced, and they did not want to take responsibility for that. One nurse compared the quality decrease with the reduced comfort and efficiency of driving a smaller and less fancy car.

> I used to drive a Mercedes, now I drive a Volkswagen beetle, but I want to drive a Mercedes. (Nurse 7)

The nurses expressed an inner fight between what they were obliged to do and their inner moral responsibility. Experiences of ethical and moral stress, but also feelings of shame and guilt, emerged when the nurses were confronted with unethical and humiliating situations, such as when corpses were stored in black plastic bags to reduce the risk of infection spread. Further, when they were not able to protect and respect the patients' integrity, such as when patients had to use a portable toilet in a crowded room without the slightest possibility for privacy. The nurses struggled with thoughts about whether their efforts had been good enough, or if they could have done things differently. Many of these thoughts involved situations of end-of-life care in which ICU treatment was withdrawn. Initially, patients died with no family member by their side because of pandemic visit restrictions. This was something the nurses experienced as immensely sad and painful. One nurse said, *"it touched my heart" (Nurse 13).* The nurses found the stricter visiting rules inhuman and fought to prevent patients dying alone. Later, they circumvented the regulations, improvised and stretched so patients and next of kin could stay in contact.

> To watch how they transform and wake up when they hear the voice of a family member, is rewarding. (Nurse 1)

The lack of next of kin, especially in end-of-life care, affected the nurses' work more than they expected. Interaction with patients' families was normally an important task for the nurses. On the one hand, the absence of family members reduced the workload for the nurses, which was appreciated. On the other hand, with no relatives present, no one was there to describe what the patient normally looked like, what kind of person he/she was, and what the patient usually preferred. The homogeneity of the patients, with similar symptoms and treatments but also features and origin, increased the feeling of dehumanization, the patients became bodies without a context.

4.5 | Theme four: The importance of supporting each other

To be there for each other as colleagues and contribute with competence and knowledge was so evident and taken for granted that the nurses rarely reflected on it. On top of the daily clinical work with patients, they supported new colleagues without formal training in ICU care. If the nurses were sick themselves and not being able to work, they felt guilty for letting their colleagues down.

> I got a pause [from work], but still, I had guilty conscience for not being able to help my colleagues when I knew that they worked like dogs. (Nurse 8)

Talking to someone with similar experiences was greatly appreciated. To chit chat before or after the work shift was highly valued and

generated spontaneous and open conversations, but it also created opportunities to share their experiences and cry together. The nurses felt solidarity when sharing each other's stories.

The collegial teamwork was important for the nurses and was experienced as interdisciplinary, supportive, encouraging, permissive, respectful and free from hierarchical behaviour. In this extreme situation, team members had to rely on each other and were proud of what they had achieved together.

> Together we must function in unity… (Nurse 8)

However, sometimes collaboration and communication with the team failed, most often across professions, such as between physicians and ICU nurses. The nurses perceived that they were tied to patients' beds and could not transfer in or out of the room as the physicians did. This loss of mobility led to that they felt excluded from discussions about treatment strategies and other interprofessional reflections, and could not participate in decision-making regarding patient care, which, in turn, was experienced as preventing the nurses from doing a good job.

Support and appreciation from the public and from first-line managers were perceived as important to enable and motivate the nurses to focus on their main task: to care for the patients. One nurse said that society treated them almost as royals. They got lunchboxes for free and got ahead of line for bike repairs. However, the nurses sometimes perceived that their first-line managers did not have the resources to accommodate the nurses' psychological needs.

> … sometimes they ask you, how you are, and when you say that you are not feeling well, they say, okay, I understand… and nothing more. (Nurse 18)

Nurses who were relocated from their ordinary workplace to a new workplace and team, sometimes felt left out and lonely. They did not know whom to turn to if they had questions or wanted to discuss their situation.

5 | DISCUSSION

This descriptive phenomenology study provides an understanding of the lived experience of altruism and sacrifices among Swedish ICU nurses during the COVID-19 pandemic, illuminating the experienced sacrifices through the following four themes; the work situation changed from one day to another, adapting to the chaotic situation, being confronted with ethical and moral challenges, and the importance of supporting each other.

Our findings are congruent with the phenomenological existential themes surrounding ontology, including lived body (corporeality), lived time (temporality), lived space (spatiality) and lived human relation/lived other (relationality or communality) (Van Manen, 1997). The nurses' sacrifices for others were illustrated by suppressing their bodily needs (lived body), pushing through long temporal episodes of work described as being in a "bubble" (lived time), and by being distanced from their normal experiences (lived space) and lack of family -centred care (lived other).

A meta-synthesis including 15 qualitative studies about health care workers' lived experiences of COVID-19 (Chandy et al., 2022) found that professional obligation, responsibility and duty to care were important driving forces in caring for suffering patients. The health care workers seemed to "join the war" without hesitation and out of professional commitments, but unexpected challenges such as shortage of staff, working long shifts in full personal protective gear and fear of being infected by the virus burdened their duty to care (Chandy et al., 2022). However, 13 of the 15 included studies were conducted in Asia, which may limit the transferability to a European context. Still, the main findings of the present study are well in line with the current evidence on the topic. In addition to these findings, our study clearly indicated a gap between the nurses' moral obligation and ambition to provide care of high quality and to protect every patient's dignity, and the actual possibility of fulfilling this commitment, which created feelings of frustration, loss of control and helplessness. This can be interpreted as suffering among the nurses, a finding that was not explicitly stated in the meta-analysis.

Arman and Rehnsfeldt (2011) explained that when nurses fail to do what they know deep down is right and good, or even do something that seems harmful to others, they also harm themselves and their moral integrity and inner ethos. Applied to our situation, the nurses perceived that they were unable to provide sufficient help to critically ill patients, a common feeling among frontline health care professionals during the COVID-19 pandemic (Emanuel et al., 2020). To witness patients' suffering awoke compassion among the nurses, which may have served as motivation and a driving force for making sacrifices for others. Working under pressure, making difficult prioritizations, not fulfilling moral and professional principles, despite every possible effort and not being able to alleviate suffering and anxiety can cause emphatic distress (Singer & Klimecki, 2014). In our study, encounters with suffering patients implied suffering among the nurses as well, however, they did not explicitly talk about suffering. Eriksson et al. (2006) claimed that people often lack the language to express highly burdensome experiences, of which suffering may be one, while Rehnsfeldt and Arman (2016) stated that metaphor and imagery are often used to grasp the meaning of difficult existential situations. In our data, metaphors were used to express what otherwise lacked words, such as "catastrophic site", "war zone" and being in "a bubble", but mental exhaustion and fatigue could also be seen as signs of suffering among the nurses. Eriksson et al. (2006) suggested that suffering makes people tired and expressing such tiredness and fatigue might be a more acceptable and convenient way to communicate suffering.

Another study conducted by Ebrahimi Rigi et al. (2022) found that nurses faced unreasonable challenges, were forced to work under extreme conditions, and their self-sacrifices and efforts to care for patients were disregarded and taken for granted. The imbalance between duties and the nurses' ability to provide adequate care led to negative impact on their health and well-being. During the pandemic, the context forced the nurses to repeatedly violate

their moral principles, and they were exposed to high levels of moral distress (Hossain & Clatty, 2021) and to ethical challenges (Falcó-Pegueroles et al., 2021), which can lead to the development of moral stress. Since moral stress increases the risk of burnout (Woo et al., 2020), this finding is worrying. To direct targeted interventions to support the well-being of nurses, identifying the causes of moral stress is important (Rhéaume et al., 2021). Even if not officially defined as a disaster, there are parallels between the COVID-19 pandemic and disaster. Disaster nursing has been described as involuntary crossing of personal, professional and environmental borders, where the individual's personal comfort zone is challenged. To recover from such experiences as a human being and on a professional level, all these three borders must be addressed (Hugelius & Adolfsson, 2019).

In the present study, the interviews were held during periods when the nurses were recalling and processing their experiences. The imbalance between work, private social life and rest might have prolonged their recovery. Rest and social support are prerequisites to managing potentially traumatic events, preventing stress-induced conditions and accommodating suffering (Hobfoll et al., 2007; Kisely et al., 2020) as communication with others (Rehnsfeldt & Arman, 2012). Also, the emotional needs of the family members of health care workers are a prosocial motivation for willingness to work under exceptional premises (Zhang et al., 2021) and should be considered from a management perspective. Therefore, building a caring and supportive culture within the professional caring team, where reflections on moral distress and other stressors are allowed, seems to be of great importance to mitigate suffering among ICU nurses deployed in pandemics.

5.1 | Limitations

Conducting in-depth interviews allowed us access to the nurses' lived experience narratives, while the nurses found it relieving to reflect on their experiences. The vast range of professional experiences among the informants, from extensive adult ICU experiences to those with experiences mainly from paediatric ICU or anaesthesiology, provided a variety of aspects of the reality of working in ICU care during the pandemic. However, most of the participants were women, highly experienced (>10 years in nursing) and all worked in an urban hospital setting. The experiences of nurses with fewer years of experience (<10 years) and those in rural settings may be different.

The study did not encompass the experiences of nurses who were on sick leave or those who chose to end their employment before or during the data collection. Thus, the most vulnerable individuals who did not cope with the situation were possibly excluded from the study. In addition, the data were collected during several phases of the pandemic, and the context of ICU care may have changed with time. This provided a broad picture of the lived experiences, but interviews during the later phases might have been influenced by the health care professionals' increasing exhaustion. Finally, since the clinical practice was hectic during the pandemic, the informants did not read the interview transcripts or the study result, which precluded corrections of potential misunderstandings and uncertainties.

6 | CONCLUSION

The current study illuminates' nurses' lived experiences of altruism and sacrifices made in frontline work during a pandemic. Taken together, being exposed to a constantly changing situation, facing the anguish and misery of patients, families, and colleagues and being confronted with a conflict between the moral obligation to provide care of high quality and the possibility to fulfil this commitment, resulted in suffering among the nurses. To cope with the situation, collegial support and supportive culture within the professional caring team were important for nurses' endurance. Also, since health care services are highly dependent on the availability and ability of nurses to handle a large influx of critically ill patients during a long period of time, such as a pandemic, all nurses need to have knowledge, competence, tools and organizational support to handle moral conflicts and distress, including support in altruistic actions for the fellow human being.

AUTHOR CONTRIBUTIONS

Anna Slettmyr, Maria Arman and Anna Schandl designed the study. Maria Arman was responsible for obtaining ethical approval. Anna Slettmyr, Chris Malmberg and Åsa Hällström conducted the interviews. Anna Slettmyr, Maria Arman, Susanne Andermo, Chris Malmberg, Åsa Hällström and Anna Schandl did a first common naïve reading of the data, while Anna Slettmyr and Anna Schandl completed the first draft of the structural analysis with input from all co-authors. Anna Slettmyr and Anna Schandl drafted the manuscript, and all co-authors reviewed the manuscript and made editorial suggestions. All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE*): (1) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content.

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CONFLICT OF INTEREST

The authors have no conflicting or competing interests to declare.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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