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Explaining nurses' experiences of dimensions of sacrifice in patient care: A qualitative content analysis

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Abstract

Introduction:

Altruism putting others' needs above one's own is a core ethical value in nursing but remains underexplored from nurses' lived experience. This study sought to describe how nurses experience the different dimensions of altruism in patient care.

Methods

We used a qualitative conventional content analysis. Twenty-five nurses working in teaching hospitals were purposively sampled for maximum variation. Data were collected through semi-structured, in-depth interviews (30–60 minutes) between November 2024 and May 2025. Interviews were audio-recorded, transcribed verbatim, and analyzed using conventional content analysis procedures. To enhance trustworthiness we used member checks, prolonged engagement with the data, and peer supervision.

Results

Analysis of 895 initial codes produced five main themes, ten subthemes, and thirty primary codes. The five themes were: Professional altruism (e.g., taking responsibility beyond assigned duty; prioritizing patients' survival), Emotional altruism (empathy and emotional support; containing personal distress), Spiritual altruism (belief in divine reward; inspiration from a martyrdom culture), Barriers to altruism (organizational neglect; perceived inequity among staff), and Consequences of altruism (physical fatigue and burnout; inner satisfaction and strengthened professional identity). Nurses described altruistic acts as both deeply meaningful and physically/psychologically costly.

Conclusion

Altruism among nurses is a multidimensional, context-dependent phenomenon rooted in professional, emotional, spiritual, and social layers of experience. Protecting and sustaining altruistic practice requires organizational policies that recognize and support caregivers, mitigate inequity, and provide psychosocial and spiritual resources. These findings have implications for nursing education, ethical policymaking, and the design of workplace support programs.

Introduction

The growth and well-being of any society depend substantially on individuals' willingness to prioritize others' needs above their own. Personality traits and values that encourage this orientation, such as altruism, serve as foundational pillars for cooperative social life. Empirical research has consistently

demonstrated that values transcending narrow self-interest are positively associated with prosocial behavior across diverse contexts (Caprara et al., 2012).

In healthcare, and particularly within nursing, these moral commitments profoundly shape daily clinical practice. Altruism is fundamentally understood as the willingness to sacrifice one's personal interests for the benefit of patients, representing a core ethical value that distinguishes nursing as a profession grounded in moral action rather than merely technical execution (Chen., 2015).

The relationship between altruism and the broader concept of care in nursing is particularly significant. Care encompasses both action (the performance of clinical tasks) and an emotional stance (being authentically present and responsively attuned to another's suffering). This latter dimension, an inner empathic commitment, illustrates how care and altruism intrinsically overlap: nurses not only perform technical procedures but also bear an affective responsibility for those entrusted to their care (Sung, 2023).

Nursing demands technical competence, yet it equally requires patience, deep compassion, and sustained dedication in the face of suffering. Moral qualities such as selflessness and commitment elevate nursing from a mere collection of tasks to a genuine vocation grounded in ethical practice (Slettmyr et al., 2023). This vocational dimension is particularly salient in cultural contexts where caregiving is framed as service, worship, or moral duty, providing powerful sources of intrinsic motivation for healthcare workers (Davoodvand et al., 2017).

Despite altruism being widely lauded as an ideal in nursing, it remains insufficiently addressed in training curricula, performance evaluation systems, and organizational policy frameworks. When altruism is conflated with related but conceptually distinct constructs such as duty, professional commitment, or empathy its unique ethical and practical dimensions may be overlooked or diluted (Rodrigues et al., 2021). This conceptual blurring, coupled with a relative lack of context-sensitive, experience-based research, has contributed to altruism's marginalization in both educational and managerial discussions within healthcare settings.

Recent literature has increasingly recognized the multidimensional nature of altruism in nursing practice. Hosseinabadi-Farahani documented how nurses providing care during the COVID-19 pandemic experienced a "transcendental" transformation, moving from initial fear and disquietude toward spiritual growth and a strengthened sense of professional transcendence (Hosseinabadi-Farahani et al., 2023). Similarly, a qualitative analysis of compassion-based care among Iranian nurses revealed that altruistic behaviors constituted a core component of prosocial responses to suffering, alongside empathy and helping in critical situations (Maringgele., 2023).

Spiritual and religious motivations have emerged as particularly significant drivers of altruistic behavior among nurses. Atkinson's ethnographic study of Muslim nurses in Kuwait found that "altruistic relationships as a core value" and the perception that "all care is spiritual care" were central themes, with participants describing nursing ethics as derived from divine rather than purely secular sources

(Atkinson., 2015). In the Iranian context, Mahmoodishan and colleagues identified that nurses' perceptions of spirituality included dimensions of "spiritual reward," "faith-based interactions and altruism," and the belief that caregiving serves as a means of seeking divine approval (Mahmoodishan et al., 2010). These spiritual framings provide nurses with intrinsic motivation and resilience that enable perseverance despite demanding conditions and lack of external recognition.

Cultural and organizational factors simultaneously shape the expression of altruism. Carter's application of Bourdieu's concepts to nursing practice revealed that altruistic motivations, while often perceived as spiritually driven, may be better understood as culturally determined habits of practice shaped by social and professional fields (Carter, 2014). Within healthcare organizations, perceived injustice and inequitable treatment significantly undermine nurses' willingness to engage in self-sacrificing behaviors (Nasrabadiet al., 2016). Vásquez-Trespalacios and colleagues demonstrated that organizational justice serves as a critical mediator in the relationship between healthcare workers' organizational identification and burnout syndrome, suggesting that fair treatment within institutions may protect against the exhaustion that often accompanies sustained altruistic practice (Vásquez-Trespalacios et al., 2023).

The consequences of altruism in nursing are paradoxical. While providing deep satisfaction, meaning, and strengthened professional identity a phenomenon described as "compassion satisfaction" (Xie et al., 2021) prolonged self-sacrifice without adequate organizational support can lead to physical fatigue, emotional exhaustion, and burnout. This duality highlights that altruism cannot be sustained by individual virtue alone; it requires institutional recognition, fair treatment, and psychosocial resources to thrive.

Given that altruism is fundamentally a lived, contextually shaped phenomenon, quantitative methods alone cannot fully capture its meanings, dimensions, and consequences for caregivers. Qualitative content analysis offers a methodological approach that allows concepts to emerge inductively from nurses' own narratives, revealing the emotional, spiritual, professional, and systemic dimensions of self-sacrifice in patient care. This study therefore employed a conventional content-analysis approach to explore nurses' lived experiences of altruism and to identify the multidimensional factors that support or impede these behaviors in clinical practice.

Methods

Study Design

We conducted a qualitative study using the conventional content analysis method (Graneheim & Lundman., 2004). This approach is well-suited for exploring phenomena where existing theory is limited and new concepts must emerge directly from participants’ narratives.

Participants and Sampling

Participants were 25 nurses employed in teaching hospitals affiliated with Sabzevar University of Medical Sciences. All had at least two years of clinical experience and had been exposed to critical care situations such as pandemics, war, natural disasters, or caring for terminally ill patients. We used purposive sampling with maximum variation to ensure diversity in gender, years of experience, hospital ward, and educational level. Recruitment and data collection took place over six months, from November 30, 2024, to May 30, 2025, and continued until data saturation was achieved.

Data Collection

Data were collected through semi-structured, in-depth interviews. Each interview lasted between 30 and 60 minutes and was conducted in a private setting agreed upon with the participant. With informed consent, interviews were audio-recorded and later transcribed verbatim. In total, 25 primary interviews were conducted, along with two supplementary interviews used to clarify ambiguous themes. Sample opening questions included:

Please share an experience where you felt your behavior reflected altruism.

What does altruism mean to you in the nursing profession?

In what situations do nurses exhibit altruism most? What factors hinder or encourage it?

Follow-up probes such as “Could you elaborate?” and “What made you decide to act that way?” were used to deepen responses and capture richer detail.

Data Analysis

We analyzed the data using conventional qualitative content analysis following Graneheim and Lundman’s framework. The research team repeatedly read the interview transcripts to gain familiarity and identify meaning units. Initial codes were generated and then grouped based on similarities and differences. Codes were further abstracted into subcategories and categories. All transcripts were coded by the first author under the supervision of the research team, who had expertise in qualitative research, nursing management, and ethics. This iterative process enabled refinement of codes and categories until a coherent thematic structure emerged.

Rigor

Lincoln and Guba criteria were considered to increase the accuracy of the study (Lincoln & Guba., 1985). The transcript of the interview is returned to the participants after coding to ensure that the researcher and the participant have the same understanding (member check). The researcher's constant mental engagement with the collected data and the process of analysis and coding indicated that he was immersed in the data. The process of coding and data analysis was supervised by experts from the research team who had sufficient experience in qualitative research, management and ethics. Maximum variability in the sampling of nursing managers was also considered. In order to increase the fitting, the

researcher tried to fully document all stages of the research, including the collection, analysis and formation of subclasses and classes, so that they could be examined by others.

Results

Participant Characteristics

Participants were selected from various departments (internal medicine, trauma, cardiology) across all three shifts to ensure maximum variance. Demographic information is provided in Table 1.

Table 1. Characteristics of study participants

Characteristics	**N**
Average age (year)	28
Gender	
Male	8
Female	17
Marital status	
Single	12
Married	13
Education level	
Bs	20
MS	5
Average work experience	7

Overview of Findings

Analysis of 25 interviews and two supplementary interviews produced 895 initial codes, which were grouped into five main themes, ten subthemes, and thirty primary codes **(see** Table 2**).** These themes capture the multifaceted and layered nature of altruism in nurses' lived experiences.

Table 2
Extracted Themes, Subthemes, and Initial Codes

Main Them	Subthemes	Initial Codes
Professional Altruism	Responsibility Beyond Duty	Volunteering for extra shifts – Staying at work during emergencies – Covering for absent colleagues
	Prioritizing the Patient's Life	Ignoring hunger and fatigue – Providing uninterrupted care for critically ill patients – Choosing to provide care despite risk of infection
Emotional Altruism	Empathy and Emotional Support	Crying with the patient's family – Listening to patients' concerns – Inspiring hope in difficult moments
	Suppressing Personal Distress	Smiling despite emotional stress – Controlling anger in the face of patient disrespect – Remaining calm after a patient's death
Spiritual Altruism	Belief in Divine Reward	Performing duties with spiritual intention – Trusting in God during hardships – Valuing humanitarian service
	Inspired by Martyrdom Culture	Drawing inspiration from martyrs – Comparing nursing to a holy struggle – Feeling a sense of national and religious duty
Barriers to Altruism	Organizational Neglect	Lack of appreciation or reward – Shortage of equipment and staff – Excessive workload
	Inequity Among Staff	Unequal distribution of rewards – Biased treatment of personnel – Overlooking individual efforts
Consequences of Altruism	Physical Fatigue and Burnout	Physical exhaustion – Reduced energy after shifts – Need for extended rest
	Inner Satisfaction and Professional Identity	Feeling proud after helping others – Satisfaction from saving a life – Sense of being useful

1. Professional Altruism

This theme reflected nurses' willingness to go beyond formal job responsibilities and prioritize patients' lives, even at personal cost. Responsibility beyond duty: Nurses described volunteering for extra shifts, staying after handover, and covering for absent colleagues.

"*After handing over the night shift, three trauma cases were admitted. I stayed and helped so things could move faster" (Participant 5).*

Prioritizing the patient's life: Many reported ignoring hunger, fatigue, or risk of infection to provide uninterrupted care for critically ill patients.

“A 3-year-old had airway obstruction. Two doctors failed to intubate. I did it myself and saved the child” (Participant 14).

2. Emotional Altruism

Nurses often concealed personal distress to provide a calm and supportive atmosphere for patients. Empathy and emotional support: Nurses listened to patients’ concerns, inspired hope, and comforted families.

“I was feeding a patient with MS. Some soup spilled. He snapped at me, but I smiled” (Participant 8).

Suppressing personal distress: Many controlled their emotions during personal crises to avoid affecting patients or colleagues.

“My grandmother passed away. We were short-staffed, so I came in at night and didn’t let anyone know” (Participant 11).

3. Spiritual Altruism

Faith and cultural beliefs emerged as strong motivators for altruistic behavior. Belief in divine reward: Some nurses saw their work as an act of worship or spiritual service.

“Sometimes I work solely for God’s pleasure, not for recognition or thanks” (Participant 2).

Inspired by martyrdom culture: Several compared nursing to a holy struggle or moral duty.

“Patients have prayed for me, saying my work is like worship. I believe that too” (Participant 18).

4. Barriers to Altruism

Despite personal commitment, systemic and organizational challenges undermined nurses’ motivation to act altruistically. Organizational neglect: Nurses cited lack of appreciation, shortages of equipment and staff, and heavy workloads.

“Some staff get high appraisals despite poor performance, while we get ignored. That kills motivation” (Participant 23).

Inequity among staff: Perceptions of unfair treatment and biased recognition discouraged self-sacrifice.

“They choose the ‘nurse of the year’ unfairly every time. It discourages self-sacrifice” (Participant 25).

5. Consequences of Altruism

Altruism was described as both rewarding and exhausting, with clear physical, psychological, and professional outcomes. Physical fatigue and burnout: Nurses reported exhaustion, reduced energy, and

the need for extended rest after shifts. Inner satisfaction and professional identity: Despite the toll, participants expressed pride, satisfaction, and a sense of meaning.

“Sure, it’s exhausting at times, but I feel proud of myself” (Participant 1).

“People respect our profession because of this selflessness” (Participant 16).

In summary, nurses’ accounts showed that altruism was not limited to professional duty but emerged as a multidimensional phenomenon professional, emotional, spiritual, and organizational. While altruism provided meaning, satisfaction, and professional pride, it was also threatened by fatigue, burnout, and systemic neglect.

Discussion

This study explored the lived experiences of nurses regarding altruism in patient care, revealing it as a complex, multidimensional phenomenon that extends far beyond a simplistic sense of duty. The findings demonstrate that altruism is deeply intertwined with professional commitment, emotional resilience, spiritual beliefs, and systemic workplace factors. These results align with and expand upon existing literature while offering new insights into the contextual and paradoxical nature of altruistic practice in nursing.

The theme of professional altruism nurses' willingness to assume responsibilities beyond their formal duties, often at personal cost echoes findings from previous research. During the COVID-19 pandemic, nurses consistently demonstrated this pattern, volunteering for additional shifts and intervening in critical moments without being asked (Creedon., 2025; Ghanbari-Afra et al., 2021). Creedon and Trace documented how redeployed nurses made significant sacrifices and revitalized themselves by creating a sense of collective identity to face harsh clinical conditions (Creedon., 2025). This behavioral pattern reflects a self-concept of nursing that transcends technical tasks to embrace a social and humanitarian role, consistent with the theoretical framework proposed by Pask, who argued that nurses' desire toward intrinsic value inevitably involves their vulnerability to self-sacrifice (Pask., 2003).

A distinctive and relatively underexplored dimension identified in this study was emotional altruism nurses' deliberate suppression of personal grief, stress, or frustration to preserve a supportive environment for patients and families. This finding aligns with observations that found compassion-based care for COVID-19 patients encompassed prosocial behaviors including altruism, empathy, and helping in critical situations (Ghanbari-Afra et al., 2021). Similarly, in the context of end-of-life care, Iranian nurses identified "innate empathy" and "individual capacity to care" as foundational motivational drivers that enabled them to understand patients' critical conditions while maintaining compassionate presence (Alavi et al., 2017). Emotional altruism thus represents more than discrete acts of care; it constitutes a "way of being" that embodies compassion, patience, and self-regulation in the face of suffering. The prominent role of spiritual motivations in participants' accounts reflects the cultural and religious context of the study setting. Many nurses perceived caregiving as a form of worship or moral

duty, rooted in beliefs about divine reward and spiritual meaning. Schreiber and Edwards found that breast cancer survivors with a more engaged view of God demonstrated altruistic orientations, using their experiences to help others rather than focusing solely on self-improvement (Schreiber et al., 2015). Davoodvand similarly identified that Iranian nurses' perceptions of spirituality included dimensions of "spiritual reward" and "faith-based interactions and altruism" (Davoodvand et al., 2017). In the context of therapeutic communication with cancer patients, Iranian nurses reported "spiritual elevation" and "acquiring religion-based strategy" as outcomes of their caregiving, suggesting that spiritual framing provides intrinsic motivation and resilience (Bafandeh Zendeh et al., 2025). This spiritual framing enabled perseverance despite demanding conditions and lack of external recognition. Despite these intrinsic motivations, the study highlighted significant organizational barriers that undermined altruistic behavior. Perceptions of inequitable treatment, lack of recognition, and resource shortages were particularly damaging to nurses' willingness to engage in self-sacrifice. A scoping review examining moral outrage among nurses found that while negative consequences such as mental exhaustion and job burnout were prevalent, positive consequences including nurses' altruism and professional solidarity could also emerge in response to moral violations (Pourteimour et al., 2025).

This paradox suggests that organizational injustice may simultaneously threaten and, in some cases, paradoxically strengthen altruistic commitment. The review further documented that altruistic nurse demonstrated compassion by adhering to principles safeguarding patient safety and wellbeing, alongside whistleblowing and advocacy for injured individuals (Pourteimour et al., 2025).

These findings underscore that altruism cannot be sustained solely by individual virtue; it requires institutional support and fairness to thrive. The consequences of altruism emerged as deeply paradoxical. Nurses derived profound meaning, satisfaction, and strengthened professional identity from their selfless acts. In a qualitative study examining outcomes of therapeutic communication with cancer patients, Iranian nurses identified "self-actualization" including inner strength, professional self-confidence, and "encouraging sense of altruism" as positive outcomes of their caregiving (Bafandeh Zendeh et al., 2025). Additionally, nurses reported "spiritual elevation" and "mutual maturity" as benefits that reinforced their professional identity (Bafandeh Zendeh et al., 2025). However, this study also revealed that prolonged self-sacrifice without adequate organizational support leads to physical fatigue, emotional exhaustion, and burnout. redeployed nurses experienced existential threats, moral injury, and compassion fatigue while simultaneously reporting post-traumatic growth and a strengthened sense of purpose (Creedon et al., 2025).

This duality which might be termed the "altruism paradox" highlights that while altruism sustains meaning in nursing, it simultaneously creates vulnerabilities when unsupported by institutional structures.

The use of conventional qualitative content analysis enabled themes to emerge inductively from participants' narratives, providing rich, contextually grounded insights.

Implications

First, nursing education curricula should explicitly address altruism not merely as an individual virtue but as a professional competency requiring cultivation and support. Students should be prepared for the emotional and spiritual dimensions of altruistic practice while learning strategies for sustainable self-care.

Second, healthcare organizations must recognize that altruism cannot be exploited as an unlimited resource. Policies ensuring equitable recognition, adequate staffing, psychological support services, and mechanisms for addressing moral distress are essential. Third, the "hero narrative" surrounding nurses during crises, while appreciative, may inadvertently discourage crucial conversations about rights, boundaries, and working conditions (Creedon et al., 2025).

Healthcare systems must move beyond celebrating individual sacrifice toward creating conditions where altruistic practice can be sustained without systematically compromising nurses' own well-being. Future research directions should include comparative studies across different cultural and religious contexts to identify universal versus context-specific dimensions of altruistic motivation. Longitudinal research examining how altruistic behaviors and their consequences change throughout nurses' careers would be valuable. Intervention studies evaluating the effectiveness of organizational support programs such as structured debriefing, peer support, and resilience training in sustaining altruistic practice while preventing burnout are urgently needed.

Strengths and Limitations

Strengths include the rigorous application of conventional content analysis procedures, maximum variation sampling ensuring diverse perspectives, and systematic attention to trustworthiness criteria including member checks and peer supervision.

Limitations include the single-country context, potential social desirability bias in participants' accounts of their own altruism, and the absence of data from other healthcare team members or patients that might provide complementary perspectives on altruistic nursing practice.

Conclusion

This study demonstrates that altruism in nursing is a multidimensional, context-dependent phenomenon rooted in professional, emotional, spiritual, and social layers of experience. While altruism provides deep meaning, satisfaction, and strengthened professional identity, it simultaneously creates vulnerabilities when unsupported by organizational structures. Protecting and sustaining altruistic practice requires institutional policies that recognize and support caregivers, mitigate inequity, provide psychosocial and spiritual resources, and explicitly address the paradox of self-sacrifice honoring its moral significance while ensuring nurses' own well-being is not systematically compromised. These findings have

implications for nursing education, ethical policymaking, and the design of workplace support programs that recognize altruism as both a professional treasure and a potential source of vulnerability requiring careful stewardship.

Declarations

Data availability

The data are not publicly available due to ethical restrictions, but they can be requested from the corresponding author, who will share them via email upon reasonable request.

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Ethics declarations

Conflict of interest

The authors have no competing interests to declare.

Ethical approval

This study was conducted in accordance with the Declaration of Helsinki. The study received ethical approval from the Ethics Committee of Sabzevar University of Medical Sciences (IR.MEDSAB.REC.1403.106). Written informed consent was obtained from all participants. Confidentiality, voluntary participation, and anonymity were strictly maintained, and all data were securely stored.

Clinical trial number: not applicable

Author Contribution

M.R. , S.M, SH.D., and A.T wrote the main manuscript text S.M, SH.D., and A.T: SamplingM.R., S.M, SH.D., and A.T: Data AnalysisAll authors reviewed the manuscript.

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