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Martyrs in Palliative Care

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In my role as a consultant to hospitals and health systems working to develop palliative care programs, I frequently encounter palliative care clinicians who exhibit signs of martyrdom. The dialogue goes something like this:

> Clinician: I am seeing a gazillion consults, up 25% from last year. Now the ICU wants me to make daily rounds and the oncologists have asked me to come to their clinic once a week. I'm feeling very stressed; I work here until 8:00 PM almost every night. I stopped collecting data on the patients we see and don't have time to do any education. I am basically working by myself; multiple requests for more staff have been rejected.
> Me: Seems like you are very overworked, perhaps it's time to put a limit on the number of consults you see until you can get more staff.
> Clinician: The hospital administration just doesn't "get it." I try and try but nothing seems to work, they have no idea how hard I am working. I think that care is suffering because I can't do all the patient follow-ups that are needed.
> Me: So how do you plan to handle the new requests to see even more patients?
> Clinician: Well of course I will do it. Sometimes it feels like I'm the only one who sees all the suffering at our hospital. I wouldn't think about not seeing a patient who needs my services.

Historically, the term martyr was used to describe someone who suffers persecution and death for refusing to renounce a belief or cause, usually religious. The word is derived from the Greek word *witness*, as in to bear witness, a believer who is called to witness for their religious belief, and on account of this witness, endures suffering and/or death. Common features of classical martyrdom include[1]:

- *A hero*: A person of some renown who is devoted to a cause believed to be admirable.
- *Opposition*: People who oppose that cause.
- *Foreseeable risk*: The hero foresees action by opponents to harm him or her, because of his or her commitment to the cause.
- *Courage and Commitment*: The hero continues, despite knowing the risk, out of commitment to the cause.
- *Death*: The opponents kill the hero because of his or her commitment to the cause.
- *Audience response*: The hero's death is commemorated. People may label the hero explicitly as a martyr. Other people may in turn be inspired to pursue the same cause.

In more recent times, a martyr is often associated with the psychological construct, a martyr complex, sometimes associated with the term victim complex; someone who desires the feeling of being a martyr, who seeks out suffering or persecution because it feeds a psychological need. This has been observed in women, especially in poor families, as well as in codependent or abusive relationships.[2,3] The desire for martyrdom is sometimes considered a form of masochism, one of several patterns of "pain/suffering seeking behavior."[4]

Does any of this sound familiar to you and your situation? If so, I'd suggest you may have features of a palliative care martyr. The key features of palliative care martyrdom are:

- The martyr believes they are both indispensible for managing all patient suffering and responsible to all patients in need;
- The martyr recognizes they are overworked and under personal stress but feels helpless to change the situation;
- The martyr feel unappreciated by those in authority, typically hospital administration.

I view martyrdom in palliative care as one extreme end of the bell shaped curve of how clinicians view their role as a responsible clinician. On one end of the curve are clinicians who take little responsibility for ensuring high-quality patient care and little commitment to the larger goals of palliative care in improving the healthcare of vulnerable patients and families. At the other extreme are individuals who devote their entire waking hours to selfless devotion to patient care, typically at the expense of their personal health and relationships with others. Fortunately, I see very view palliative care professionals who take little responsibility; the opposite extreme is far more common. In fact, in palliative care the bell-shaped curve is not bell shaped at all but skewed far to the side of high clinician responsibility. It is this fact that has likely been responsible for the rapid uptake of palliative care services; we generally provide exceptional care fostered by a high degree of internally driven sense of responsibility.

The problem arises when that sense of responsibility becomes overwhelming, obscuring our sense of self and harming our relationships with those around us—we lose the boundaries necessary for healthy professional and personal relationships. Although it is easy to blame the "system" for failing to provide sufficient resources to lessen the burden on the martyr, I would suggest that the internal drivers that maintain the state of martyrdom are far more important to understand and ultimately address.

Here are some concrete steps I recommend when I encounter individuals with features of palliative care martyrdom.

- Look in the mirror, or ideally, have a trusted team member or other coworker help you look in the mirror,

to reflect on your current activities. Think about your current work load and the beliefs that are driving you to work harder. Are the beliefs rational? Are they contributing to your health and growth as a caregiver? Are they sustainable?

- Make a commitment to take ownership of the problem rather than blame hospital administration, your coworkers, or others. Recognize that you are part of the problem; the irrational belief that only you can relieve suffering only enables a dysfunctional health care system that is more than happy to let you work yourself to death.
- Complete a burnout self-assessment; martyrdom may be a sign of professional burn-out.[5]
- Seek out professional counseling or a career coach.

Caring, competent, and dedicated palliative care clinicians are a scare resource. The work is hard, and as palliative care becomes ever more integrated into the fabric of our health care system, the work will only increase. We owe it to our families, coworkers, and patients to take care of ourselves. Being a martyr to palliative care is not healthy and ultimately, will not bring about the larger changes in clinical care improvement that we all seek.

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