Leadership Development Initiative: Growing Global Leaders... Advancing Palliative Care

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Abstract
The International Palliative Care Leadership Development Initiative (LDI) was a model demonstration project that aimed to expand the global network of palliative care leaders in low- and moderate-resource countries who are well positioned to apply their new leadership skills. Thirty-nine palliative medicine physicians from 25 countries successfully completed the two-year curriculum that included three thematic residential courses, mentorship, and site visits by senior global palliative care leaders and personal projects to apply their new leadership skills. The focus on self-reflection, leadership behaviors and practices, strategic planning, high-level communication, and teaching skills led to significant personal and professional transformation among the participants, mentors, and the LDI team. The resulting residential course curriculum and the personal leadership stories and biosketches of the leaders are now available open access at IPCRC.net. Already, within their first-year postgraduation, the leaders are using their new leadership skills to grow palliative care capacity through significant changes in policy, improved opioid/other medication availability, new and enhanced educational curricula and continuing education activities, and development/expansion of palliative care programs in their organizations and regions. We are not aware of another palliative care initiative that achieves the global reach and ripple effect that LDI has produced.

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Key Words
Leadership, international, palliative care, hospice, physician, global, LDI, Leadership Development Initiative

Background
Subsequent to their extensive experience with the Project on Death in America and many efforts internationally, the leadership of the International Palliative Care Initiative (IPCI) at the Open Society Foundations realized that new leadership would be needed if efforts to grow palliative care capacity internationally were to be sustained.

To establish a consensus about the need for leaders with skills in developing countries, IPCI convened a group of existing international leaders in palliative care in London in February 2009. The group included many of the regional experts and now senior leaders that IPCI had supported in Central and Eastern Europe, Africa, and Asia. The participants were members of national, regional, and international palliative care associations, university faculty, civil society organizations, and other palliative care donors. The group was asked to reflect on their own evolution as leaders and to put forth ideas and important ingredients for a leadership development program. There was consensus that an international leadership development initiative (LDI) should be developed for emerging palliative care leaders in low- and moderate-resource countries who were well positioned to apply leadership skills.

To launch and support the model demonstration project and framework for the International Palliative Care Leadership Development Initiative, IPCI partnered with the National Cancer Institute, The Diana, Princess of Wales Memorial Fund, National Publication of this article was supported by Public Health Program of Open Society Foundations. The authors declare no conflicts of interest.

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Hospice and Palliative Care Organization, and the Pettus Family Foundation. In 2009, because of the considerable experience in operationalizing educational initiatives and international outreach already well structured, IPCI offered the implementation opportunity to the faculty of the Institute for Palliative Medicine (IPM) at San Diego Hospice, San Diego, CA, and the International Palliative Care Leadership Development Initiative was born. From 2009 to 2012, LDI was based at IPM. In 2013, LDI transitioned to be based at the Ohio Health Research Institute in Columbus, OH.

The aim of this model/demonstration leadership skill-building course was to “Grow global leaders and advance palliative care” through practical experiences. Specifically, LDI aimed to:

1. Identify and develop the leadership skills of physicians in low- and moderate-resource countries (as defined by the World Bank) who were positioned to become the next generation of leaders and who had the potential to increase palliative care capacity in their country/region
2. Create a network of the next generation of skilled palliative care leaders to facilitate increased palliative care capacity worldwide, and through the experience of the program link, this network more closely with current palliative care leaders throughout the world
3. Link these new leaders to existing international resource centers and programs
4. Establish a sustainable approach to palliative care leadership development that can be catalytic, transferable, and replicated across disciplines and ultimately used to support capacity enhancement in both resource rich and resource-limited countries.

Methods

In 2009, palliative care physician leadership programs were nonexistent, and even physician leadership programs were difficult to find. When reviewed, existing programs seemed more about financial and management skills than the promotion of leadership that would lead to building palliative care capacity in developing countries. A variety of university master’s level and some corporate leadership development curricula were also reviewed. No one program matched the variety and depth of skills thought to be critical for the physician-leader and with the goals of the LDI. Existing leadership theory was used with the palliative care mission in mind.

Based on their previous experience with successful and innovative educational programs, the Leadership Team at IPM developed and evolved a multiyear model Palliative Care Leadership Development demonstration project. The educational intervention was designed based on the prevailing understanding that:

- Mentorship significantly helped learners develop skills and change behaviors
- Personalized on-site consultation/mentorship resulted in increased and significant impact
- Knowledge alone is insufficient to bring about change (Dixon).

Four conceptual frameworks were used to develop the overall curriculum:

2. Developing the Leader Within You, by John C. Maxwell.
3. 7 Habits of Highly Effective People, by Steven R. Covey.
4. The Public Health Strategy for Palliative Care, by Jan Stjernsward, Kathleen M. Foley, and Frank D. Ferris (see Fig. 1)

Acquiring personal leadership skills and opportunities to practice and to apply these new skills in real-life palliative care contexts was a high value. The participants, by virtue of having been nominated and selected, were already in various stages of their leadership journey. The curriculum was designed to learn, practice, and polish leadership skills while advancing their knowledge and skills to effectively lead in the current setting and in progressively wider spheres, that is, their community, nation, region, or globally.

The model demonstration project started by focusing on “self”-leadership as knowledge, skills, attitudes, and behaviors of leaders begins from the inside out. By expanding/deepening these skills, the curriculum aimed to promote leaders’ capacity to influence and lead teams and organizations, and from there, widen and practice skills that would foster powerful regional and international leadership. Mentorship and small group interactive activities were built into the program, with structured practical

![Fig. 1. Public health model for palliative care.](image-url)
exercises and challenges to practice skills both at the residential courses (RCs) as well as on their own home front.

There were two sequential cohorts used to develop/evolve an effective LDI curriculum. The curriculum and evaluation strategy was reviewed and approved by the Institutional Review Boards at IPM and subsequently at Ohio Health Research Institute, Columbus, OH.

- Cohort 1: Pilot curriculum (January 2010–December 2011)
  - Pre-work, three RCs (in San Diego), individual development plans (IDPs)
  - Intersession activities
  - Evaluation of sessions, courses, overall cohort experiences, changes in attitudes, knowledge, and skills
  - Feedback to fine-tune Cohort 2 curricula
- Cohort 2: Curriculum delivery (January 2012–December 2013)
  - Pre-work, three RCs (two in San Diego and one in Columbus), IDPs
  - Intersession activities
  - Evaluation of sessions, courses, overall cohort experiences, changes in attitudes, knowledge, and skills
  - Reporting of “personal leadership story,” completion of personal Web page, lead and promote palliative care globally.

Because the Cohort 1 curriculum was a pilot and served to provide feedback for the development and delivery of the Cohort 2 (C2) curriculum, the article reports on the curriculum and evaluations/outcomes of the C2. The entire curriculum presented during the three RCs of C2 been placed at http://www.ipcrc.net/ldi-curriculum-overview.php for open access by anyone who wishes to learn from the presenters and/or use the PowerPoints to make a presentation or use the curriculum in its entirety.

**LDI Leadership Team**
At IPM, the LDI Leadership Team included:

| Frank D. Ferris, MD, FAAHPM, FAACE, LDI Director | Shannon V. Moore, MD, MPH, LDI Co-Director |
| Helen McNeal, BA, Executive Director | Eileen M. Piersa, MS, MA, Manager, Special Projects |
| Stephanie Whitmore, BA, Evaluation Coordinator | Judi McCarter, MT, AA, BS, Director, Grant Manager |
| Debra Pledger-Fonte, Administrative Assistant | Paula Frampton-Brown, Administrative Assistant |

**Participant Selection**
The LDI team used a variety of international palliative care newsletters to disseminate a global call for palliative care physicians who were seen to be emerging leaders in low- and moderate-resource countries to apply for C2 of the LDI model demonstration project. Initially, the LDI team reviewed each application; then, each application was reviewed by three external palliative care experts who did not know the applicant. The finalists were interviewed by the LDI team by phone to answer questions, ensure commitment, and assess English skills.

**Residential Courses**
During C2, the LDI team hosted three week-long RCs for the leaders and mentors in February 2012, October 2012, and October 2013. The overall goals of these RCs were to:

- Build relationships among the leaders, mentors, coaches, and LDI team and with guest faculty
- Foster teamwork and networking and build community to increase global reach
- Develop and practice new personal and leadership knowledge and skills
- Reinforce thematic content and skills development
- Review each leader’s personal and organizational Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis, develop, and refine each IDP and budget with mentors, coaches, and the LDI team
- Experience mentorship so as to acquire skills to become a mentor (an advanced leadership skill).

Each RC had a number of “through themes” that built and reinforced foundational content and skill building (see headings in Table 1). The focus on relationship building and networking, supported by the mentor and coaching relationships, was an important aspect of the initiative and served to create a safe environment for authentic and sustainable development.

During and in between these RCs, the leaders developed their own IDP and were mentored by a senior palliative care leader-mentor and the LDI team coaches. They were expected to practice their skills, lead their teams and organizations, articulate values, and model their own leadership philosophy. The continuous leadership skill building and the emphasis on practicing leadership skills was the key to success; the leaders affected their setting and context in profound ways. They came to better understand the impact of developing “self” vis-a-vis the advancement of their palliative care leadership capacity.

**Mentorship**
In the review of university and corporate leadership programs that contributed to the design of LDI, it was clear that mentors and mentorship are one of the most important ingredients in the successful development of
<table>
<thead>
<tr>
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<th>Residential Courses Overviews</th>
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<td><strong>RC2: Developing Leadership Within Your Organization</strong></td>
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<td>Pre-course work and evaluations</td>
<td>Pre-course evaluations</td>
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<tr>
<td>● MBTI</td>
<td>● Leadership skills</td>
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<td>● LPI</td>
<td>● Leadership attitudes</td>
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<tr>
<td>● Situation analysis (organization and region)</td>
<td>● MBTI</td>
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<tr>
<td>● Leadership skills</td>
<td>● Leadership skills</td>
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<tr>
<td>● Leadership attitudes</td>
<td>● MBTI</td>
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<tr>
<td>● Prelim IDP</td>
<td>● LPI</td>
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<td>● Personal SWOT analysis</td>
<td>● MBTI</td>
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<td>● Organizational SWOT analysis</td>
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<td><strong>Communication skills</strong></td>
<td><strong>Communication skills</strong></td>
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<td>● Conflict style</td>
<td>● Leadership skills</td>
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<tr>
<td>● Communication and MBTI</td>
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<tr>
<td><strong>Activities</strong></td>
<td><strong>Activities</strong></td>
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<tr>
<td>● Complete IDP</td>
<td>● Strategic planning process: New in-patient PC unit PC Program</td>
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<td>● Complete associated budget</td>
<td>● Development National Association Homecare</td>
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<tr>
<td>● Complete the situation analysis</td>
<td>● Sandcastle exercise (team building)</td>
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<td><strong>Feedback</strong></td>
<td><strong>Feedback</strong></td>
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<tr>
<td>● How to give</td>
<td>● Giving/receiving</td>
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<td>● How to receive</td>
<td>● Asking for feedback</td>
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<td>● How to use body</td>
<td>● Practice small group</td>
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<td>● How to use voice</td>
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<td><strong>Change management</strong></td>
<td><strong>Change management</strong></td>
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<td>● Four-stage change model</td>
<td>● Kotter’s eightstep change process</td>
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<td>● Modeling change behaviors</td>
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<td><strong>Leadership frameworks</strong></td>
<td><strong>Leadership frameworks</strong></td>
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<tr>
<td>● Kouzes and Posner</td>
<td>● Kouzes and Posner</td>
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<td>● Maxwell</td>
<td>● Maxwell</td>
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<td>● Covey</td>
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<td><strong>Explore “self” as leader</strong></td>
<td><strong>Leading a team</strong></td>
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<tr>
<td>● MBTI</td>
<td>● MBTI and leadership</td>
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<td>● LPI</td>
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<td>● Values of leadership</td>
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<td><strong>Conflict Style Inventory (Kraybill)</strong></td>
<td><strong>Conflict Style Inventory (Kraybill)</strong></td>
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<td>● Association membership(s)</td>
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<td>● Local mentor</td>
<td>● Local mentor</td>
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<td>● Global mentors</td>
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<td>● Peer mentorship</td>
<td>● Peer mentorship</td>
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<td></td>
<td>● Networking</td>
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<td><strong>Teaching/learning skills</strong></td>
<td><strong>Strategic planning</strong></td>
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<td>● Kolb learning style</td>
<td>● Fundamentals of project management</td>
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<td>● Adult learning</td>
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<tr>
<td><strong>Planning tools</strong></td>
<td><strong>Planning tools</strong></td>
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<tr>
<td>● Completing the situation analysis:</td>
<td>● Strategic planning worksheets</td>
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<tr>
<td>● Finding the data</td>
<td>● Overview of strategic and business planning</td>
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<tr>
<td>● Financial planning: budget-expenses-reconciling</td>
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<tr>
<td>● Completing the IDP</td>
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**MBTI** = Myers-Briggs Type Indicator®; **LPI** = Leadership Profile Inventory®; **IDP** = individual development plan.
Regional Mentors. From the earliest conception of the LDI, there have been a host of senior global palliative care clinicians, educators, and leaders who had wished to learn from and contribute to LDI. Mentors were selected for their expertise in palliative care and their exemplary leadership roles. All of them had a wide range of palliative care education and leadership in low- and moderate-resource countries. During the two years of the LDI, the mentor—mentee relationship was encouraged and deepened, with required frequent “check-ins” between the RCs and concentrated time together at each RC. The mentors were most involved in the development, refinement, and actuation of meaningful IDP goals and activities, the blueprint of each leadership journey. In addition, because the on-site visit of mentor to leader’s context was so fruitful in the first LDI cohort, it was a sponsored and mandatory experience in C2. For a full list of mentors from C1 and C2, see http://www.ipcrc.net/news/category/international-leaders/#mentors.

In-country mentorship: Leaders were encouraged to seek additional mentoring from in-country and regional resources.

Peer-to-Peer Networking. In addition to faculty and other mentors, several of graduate leaders from C1 supported the C2 leaders.

LDI Coaches

Although each leader had a mentor, emerging professionals benefit by the counseling and support from the different perspective offered by a coach. Each coach was assigned several mentor-learner dyads to follow. Besides offering general support, LDI team coaches had frequent contact with leaders and mentors, offered personal coaching around work-life balance, characteristics, strengths and skills of leadership, and underscored accountability and support for accurate and timely reporting: interim reports, expense reports, Web page entries, leadership story, monthly reflections, etc.

A particularly unique component in leadership development was championed by Ron Cameron-Lewis, our Media and Communications Consultant, as one of the most important skills of leadership is the ability to communicate, verbally and nonverbally. Voice and body language skills improvement exercises, accent modification, developing an on- and off-camera presence, and sharing feedback on videotaped presentations enhanced confidence and sparkle of the leaders. See http://www.ipcrc.net/news/category/international-leaders/#coaches and http://www.ipcrc.net/news/category/faculty-staff/.

Advance Preparation

Once selected, each leader completed a:
- Letter of Commitment signed by the leader and his/her supervisor.
- Personal Web page at http://www.ipcrc.net/news/category/international-leaders/
- Situation analysis
- Personal and organizational SWOT analysis
- An initial draft IDP and budget. Activities included projects in policy development, drug availability, program development, or educational leadership. Progress and/or success was reported based on the IDP timelines and registered activities.

Press Releases

Press releases were created and distributed to standard media outlets announcing opening of second cohort (C2). Templates were created for leaders to use locally to announce their participation in LDI.

Stipend

A modest stipend was offered to each leader to use to build leadership skills or to provide an opportunity to practice leadership skills.

Reading/Reflecting/Journaling

To stimulate discussion and reflection, Web casts and reading or writing assignments were scheduled between RCs. Monthly reflective journaling exercises focused on self-development.

LDI Resources

The list of leadership resources continually expanded over the multiyear project. They are readily accessible at http://www.ipcrc.net/who-program-leadership.php. For the greatest detail on specific resources used for any particular RC, go to the http://www.ipcrc.net/ldi-curriculum-overview.php.

Consultative Site Visits by Mentors

During C2, mentors visited their leaders’ workplaces, most during the first 12 months. Before any visit, goals, a detailed plan and a budget was developed by the leader and approved by the mentor and LDI team.

Personal Leadership Stories

The profoundly personal transformation experienced by leaders was captured in their personal leadership stories that they created before graduation to
document their leadership journeys. See www.ipcrc.net/news/category/international-leaders.

Participant Reporting
Between RCs, frequent phone or SKYPE contact with mentors and coaches facilitated IDP development, review of progress to date, and setting of clear goals for the next quarter.

Participants submitted annual narratives and financial reports and the quarterly reports described earlier.

Evaluation Strategy
A number of tools were developed to measure progress and evaluate the effectiveness of LDI, including:

- Attitudes, knowledge, and skills assessments
- RC session and overall course evaluations
- Leadership Attitude Survey and Core Skills Evaluation (quantitative)
- Networking and Collaborative Relationships Inventory (qualitative)
- Mentor consultative site visit evaluations
- Overall cohort evaluations that were completed at the end of the second year and are being completed each subsequent year for three to five years.

After consenting to participate in the evaluation strategy, all data were collected via StudyTRAX, a data management system.

Results
Participant Selection
For C2, more than 130 people submitted applications that were reviewed in two phases by the LDI and IPCI teams and then by 24 external reviewers who are global palliative care leaders. Based on all comments and ratings, 23 applicants were selected to participate in C2; three participants were lost to attrition before RC3; 20 participants (91%) completed the full two-year C2 program. Including the graduates of C1, a total of 39 leaders from 25 countries completed the four years of the LDI model demonstration project (Fig. 2). For the full list of LDI leaders, see Table 2. To review their biosketches and leadership stories, see http://www.ipcrc.net/news/category/international-leaders.

Mentor Selection
From the beginning, internationally recognized palliative medicine leaders and faculty demonstrated passion and interest in participating as mentors. The mentors who were able to participate in both cohorts brought extra depth and wisdom to the evolution of the initiative and elevated the learning for all concerned leaders, faculty, LDI team, and mentors alike. For a full list of mentors from C1 and C2, see http://www.ipcrc.net/news/category/international-leaders/#mentors.

Evaluation of Attitudes, Knowledge, Skills
Throughout C2, leaders self-evaluated a variety of skills, attitudes, and knowledge about leadership. Figure 3 demonstrates the outcomes of the self-evaluation of leadership skills over the three RCs:

1. leadership of “self”
2. leadership within their organization
3. leadership beyond the organization to national or international levels.

The retrospective responses demonstrated that the leaders were relatively overconfident in their self-assessments at baseline and underscore the reality of “blind spots” that may affect any of us at any level but is especially true for a relative new skill or learning process. The curves also show a nice improvement in each of the three leadership foci.

Attitudes Survey, Quantitative
The Attitudes Survey rated 19 statements about attitudes toward leadership using a six-point Likert scale before each RC. Significant differences ($P < .05$) over the time were only found for four statements:

1. Leadership development is self-development.
2. The best leaders are also the best learners.
3. The work of leaders is to search for opportunities to change the “way things are.”
4. Risk taking is a feature of powerful leadership.

Session and Overall RC Evaluations
As would be expected, course evaluations revealed that participants:

- Enjoyed the majority of the sessions presented
- Acquired new knowledge related to palliative care leadership during this course

When asked how mentorship interactions affected their course experiences, participants noted positive relationships with their mentors,

“It was a great experience for me, I have always wanted to have a mentor who can help and guide me in my professional life. We got off to a great start and I am sure we will get along very well,” “The interaction enhanced my experience. It was very productive and enlightening,” and “I was supported, I was taught different ways to relieve my anxiety, it was really helpful to come out more naturally than before.”

When asked to describe the value of the RCs,

In the course of one’s career and growth it takes years to acquire the skills of leadership and one may still not pick them up. There are so many steps and hurdles in
being a leader. This course helped me learn a lot. It has given me a road map. I think it has helped to fast forward my growth. It has also given me tips on how to handle things that I had no exposure to. Instead of 'trial and error, learning the hard way' I think I have a more learned approach to many issues.

I think that LDI achieved an outcome for each of its participants in a highly individualized manner. It focused not only on concrete objectives but initiated a dynamic process of reflection and observation on oneself. One is allowed to define leadership in an individual manner and work on themselves. There is a choice and freedom in defining oneself.

*Mentor Consultative Site Visits*

Experience during several initiatives has shown that consultative site visits by mentors to participant’s workplaces may be one of the most beneficial activities in an educational initiative intended to build palliative care capacity. The following outcomes resulted from time together:

- Allowed greater understanding of the leader’s resource limitations and realities
- Meetings with a host of department heads, advisory boards, stakeholders, and academics
- Strategic planning processes for advancing IDP and five-year plans more widely
- Increased credibility for the mentee in their own context to have an internationally renowned palliative care (PC) leader
- Augmented and strengthened the mentor-mentee relationship
- Augmented and strengthened the PC approach and concepts in many settings
- Mentors often lectured or participated in identified team teaching exercises to give feedback on teaching, communication, and facilitation skills
- Mentors sometimes assisted in conflict resolution or reconciliation of difficult situations
- Press releases, video, and TV interviews were planned to increase depth and breadth of awareness.

The presence of my mentor in Guatemala was of great benefit to provide support to my activities regarding leadership skills, PC development, and implementation. The institutions where I work were open to receive her and have her speak about the LDI program. All of them were very well impressed about the investment in my leadership, having an international authority in Palliative Care visiting from an U.S. program. Important

**Table 2**

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<tr>
<th>Cohort 1, 2010–2011</th>
<th>Name</th>
<th>Country</th>
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<tr>
<td>Agnes Csikos</td>
<td>Hungary</td>
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<td>Anil Kumar Paleri</td>
<td>India</td>
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<td>Bich Thuy Bui</td>
<td>Vietnam</td>
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<td>Folaju Oyebola</td>
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<td>Gayatri Palat</td>
<td>India</td>
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<td>George Low</td>
<td>Tanzania</td>
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<tr>
<td>Hanneke Brits</td>
<td>South Africa</td>
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<td>Henry Dlungu</td>
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<td>John Weru</td>
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<td>Khanh Thanh Quach</td>
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<td>Ladislav Kabelka</td>
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<td>Mohammad Bushnaq</td>
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<td>Ondrej Slama</td>
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<td>Patrick Akhiwu</td>
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<td>Sofia Bunge</td>
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<td>Urska Lande</td>
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<td>Vadim Pogonet</td>
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<td>Zipporah Ali</td>
<td>Kenya</td>
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<th>Cohort 2, 2012–2013</th>
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<tr>
<td>Anjum Khan Joad</td>
<td>India</td>
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<td>Dinesh Chandra Goswami</td>
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<td>Ali Xhixha</td>
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negotiations took place during Deborah’s visit that will allow me to advance PC education at the public university and continue to develop the PC team at the Cancer Institute.

It was one of the best opportunities I have had in my experience, having him available for all the time was a great opportunity for me and my colleagues. I had really quality time with him; working, discussing, learning much and having some fun.

Several of the visits resulted in a very different slant on a previously identified priority item, development of greater clarity in the goal-setting process, and being able to avoid wasting time and efforts.

**Overall Cohort Experience**

Although many aspects of the course were evaluated, when asked, “How would you describe the LDI to a colleague, and would you recommend the experience to them to help them grow in leadership skills, knowledge and behaviors? And/or, to advance palliative care globally?”

LDI is a life transforming experience which as Palliative Care is integrative and structured. It gives you the tools to learn and allows you with experiences and networking to develop that learning; it works with your whole person: Body, mind and soul; it has given me the opportunity to learn through all

![Fig. 3. Core skills—mean scores of C2 leaders categorized by question type.](image-url)
my senses and capacities how to improve my leader-
ship skills and how to manage changes within myself
and in my country. A Palliative Care physician is not
enough to change the system, a leader in palliative
care will make the difference.

LDI is more than a simple course about leadership.
It is an international task force to develop leaders in
PC all around the world. I strongly recommend it to
a colleague to help them grow in leadership skills,
knowledge and behaviors to advance PC globally.

Participants indicated that the mentorship and
couch interactions were an important part of their
learning experience.

They helped me, the mentors with leadership in palli-
ative care. Able to ask for guidance. The coach help me
understand myself better and get emotionally stronger.

It was a great experience for me especially since my
mentor taught me how to analyze or assess my
perceptions/feeling or attitude towards issues or
people and make unbiased decisions about
different issues. This has greatly improved my ability
to work with a team and value every member.

I think that the interaction with the mentors and
the couches is one of the most important aspects
of the RC. In the lobbies, during breaks and
lunches, there is a parallel curriculum that is as
interesting as the programmed course. I learned a
lot through the advice and conversations I had
with my mentor and the rest of the LDI team.

Several of the participants indicated that LDI was a
life-changing course for them.

At the beginning I thought leadership was a ques-
tion of hierarchy and required a strong character.
I did not understand the broad meaning of leader-
ship. LDI training made me realize that leadership
is a relationship. A leader must be able to envision
a better future, inspire others with his/her vision,
initiate the change, and enlist participation of
others to achieve the set goals and respect and value
their contributions. LDI made me understand that
anyone can aspire to leadership because everyone
has inherent leadership qualities which can be
developed through training or modeling.

The LDI was the best learning experience I’ve had in
my life, not only because it gave excellent useful ma-
terial, but the framework from the insights of myself,
made me grow as a human being and not only be the
best leader I can be, but also to be a happier person,
with more focus on the real important things. I find
the curricula excellent, because all the information
received, it’s extremely useful, powerful and with
great academic level. I observed a big transformation
of myself, in the lifelong journey of learning and hav-
ing more experiences, this course has been of invalu-
able importance in my life.

**Leadership Resources**

They are readily accessible at [http://www.ipcrc.net/
who-program-leadership.php](http://www.ipcrc.net/who-program-leadership.php). For the greatest detail on
specific resources used for any particular RC, go to the

**Impact**

It is nearly impossible to capture and summarize the
exhaustive details of what this energetic and powerful
group has accomplished. Graduates of LDI have
already demonstrated that they are the next genera-
tion of local, national, and global palliative care
leaders. They have taught, published, networked, and
served as visionary directors and/or coordinators
of university pain and palliative care units, founda-
tions, international, and national associations. Exam-
les of their accomplishments include:

- **Policy**
  - Leaders are advisors to regulatory commissions in
    health
  - Leaders sit on advisory and scientific councils
    with Ministries of Health.
  - Increases in the number of national health
    policies that now include palliative care
  - Palliative care issues have been expanded and
    incorporated into the noncommunicable disease
    strategy in Bangladesh
  - New laws were signed in Albania, Guatemala,
    Armenia, and Colombia.

- **Medication Availability**
  - Changes in laws and regulations have made
    opioids more available in several countries
  - With the help of the leaders, the production of
    oral morphine is underway and expanding in
    needy countries (Nepal, India).

- **Education and Research**
  - Many advocacy activities to increase public
    awareness
  - Many palliative care oral and poster presentations
    at local, national, and international conferences
  - Leaders have been selected to serve significant
    roles in European Association for Palliative Care
    (EAPC) and Asia Pacific Hospice Palliative Care
    Network (APHN) meetings.
Multiple new undergraduate and postgraduate medical and curricula for other disciplines that include palliative care

New palliative medicine fellowship training programs

Recognition of palliative medicine as a medical specialty

Creation of new palliative medicine university departments and research centers and initiatives

Leaders are professors, principle investigators, academic coordinators, and consultants for new medical school courses, and new research initiatives in palliative care

In Prague, Czech Republic, there is a “first-ever” palliative care research center being established.

Program Implementation

Leaders have started the “first-ever” home care programs, regional and local palliative care and health care facilities.

Increases in the number of inpatient and home palliative care services in their organizations and their regions

Significant increases in the numbers of patients and families receiving palliative care in their respective programs

Palliative care as a specialty service with defined professional roles and legislation that allowed more liberalized drug availability were formalized and approved.

Discussion

The great gift of LDI is the opportunity for leadership behaviors in palliative care to evolve, be embraced, and replicated with greater and greater confidence by the leaders in their settings. Comparison of C2 pre-and post-intervention inventories demonstrates that the LDI curriculum and exposure to international palliative care mentors increased awareness and changed attitudes about personal capacity and leadership, resulting in a sustainable impact on the leaders, their organizations, and the patients and families they engage with.

The primary outcome of the initiative is the nurturing of emerging leaders who expand the cadre of palliative care experts and have the potential to advance the field of palliative medicine throughout the world. An intended by-product of the initiative was the development of a palliative care leadership development curriculum and process that can be used for the development of leaders in resource-rich and resource-limited countries. Ideally, this could be expanded to include leadership development for other health care professional disciplines, including nursing, social work, etc. It has the potential to be marketed and commercialized as a leadership development process for palliative care practitioners within organizations. This initiative serves as a useful pilot program to help develop a more extensive business plan for the long-term sustainability of an LDI in palliative care. Already leaders and mentors are running leadership courses and teaching components of leadership skills development in a variety of settings, including an adaptation of LDI has formed the foundation for the European Palliative Care Academy (EUPCA) course funded by the Robert Bosch Foundation in Germany and another program in Sweden. Mini courses have been given at several different meetings, including the American Academy of Hospice and Palliative Care and the Latin American Palliative Care Association.

Palliative care leaders in resource-limited countries have applied for funding and paid for distant learning programs in palliative care to obtain certificates in palliative care or masters in palliative care. Many of these have been co-funded by their own institutions or organizations, and in the long run, it is possible that sustainability of this initiative will be based on some payments made by the participants along with ongoing philanthropic support. LDI could also be adapted for participants from resource-rich countries and the revenue obtained from such programs may be able to partially support the infrastructure costs for running the entire program and maintenance of the curriculum dissemination and all the other educational components.

We hope this initiative will be sustainable and demonstrate the important role that LDIs can play as a catalytic force to facilitate the development and integration of palliative care capacity.

LDI is successful because of its catalytic effect at increasing the attention to the importance of palliative care leadership development worldwide. The LDI curriculum is freely accessible on IPCRC.net, with a base of Web-based resource materials and tools. It can be adapted and used by anyone; for emerging leaders in high- and low-resource countries, such as North America, Europe, and Australasia and for professions beyond medicine.

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