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Active Learning to Become an Effective Leader – A Long Tortuous Journey

Leadership Within

"Some are born great, some achieve greatness, and some have greatness thrust upon 'them"[i]. Could this be said about all leaders? Whether leadership is innate or acquired, what determines a leader's greatness is their effectiveness and influence within their field. There is no doubt that either model would benefit from expanding their leadership skills.

Background history

As the firstborn of six siblings, my father always taught me to exhibit leadership and responsibility with the younger ones. This role was my watchword till the time I became independent and joined the larger macro society.

My primary background is anesthesiology before sub-specializing in pain and palliative medicine, which means I entered palliative care through the backdoor. My foray into a leadership role began in 2000 when I was reluctantly elected as the Hospital Director of Clinical Services and Training without any previous leadership experience. It could be said leadership was "thrust" upon me. My goal then was to be fair, ensuring equity and justice for all staff.

Ms Carol Stack in collaboration with US Public Affairs came to our Centre in 2002 to present a paper on palliative care, an event which I facilitated. To some participants, her words fell on rocky ground. But in my case, they fell on fertile ground in my heart and began to grow. I subsequently took the initiative to form a multidisciplinary palliative care team at the hospital.

However -- to my surprise -- only one of the foundation members reached the Promised Land with me. Others lost hope and faith in the project within a year or two. It was a case of a blind man leading a group of blind people, but the exercise became more meaningful after I had a formal training in the field.

My second leadership opportunity came in 2007 when, as a founding member of the Hospice and Palliative Care Association of Nigeria (HPCAN), I was elected as the first National Secretary General. In both these leadership roles, I only had a faint idea of how to model the way through uncharted waters. I tried my best but with benefit of hindsight, I realize I could have done better had I known then what I know now. I have honed my leadership skills through the LDI program at the Institute for Palliative Medicine at San Diego Hospice.

Local Challenges (Circle of Influence)

I still vividly remember some of the challenges I faced as director of clinical services and training. On some occasions I had to resolve emergency strike actions by hospital workers as fast as possible to allow a continued smooth running of the hospital. Such emergencies challenged my ability to control a crisis. To some I was viewed as a weak leader; to others I was seen as a very compassionate person. Some heads of units regarded me as too officious and today some staff see my tenure as very successful.

Despite these challenges, I was able to make some impression on the hospital management. In 2008, management unanimously approved my proposal to establish an independent pain and palliative medicine department. I was appointed as the first full-time palliative care physician of the first hospital based palliative care department in Nigeria. Before that time, few saw any future for palliative care as a career pathway in my country. Today there are more than eight similar facilities in Nigeria with full-time doctors and nurses.

The challenges were enormous for an emerging leader, saddled with the responsibility of forming a multidisciplinary team and providing new services in a system where nothing was known about palliative care. The adage that "No prophet is accepted in his own country"[ii] perfectly fits my situation as there were several local resistors among colleagues and staff who felt we were just trying to duplicate their functions. In addition there was no national policy on palliative care.

It took frequent visits from UK palliative care colleagues to win the confidence of many of the senior hospital community. Some thought I was committing heresy and that there was nothing new in providing pain and symptom control, nor care and support for patients. There is a risk of similar opposition for anyone who develops new approaches elsewhere in medicine. Bringing change demands hard work to achieve success.

Establishing a National Agenda

In the development of palliative care, countries in West Africa lag behind East and South African regions. Some few years back, whenever I participated at international palliative care conferences, I used to feel disappointed not seeing the Nigerian flag among other nations. Although there has been a flurry of palliative care activity in Nigeria, there has been little co-ordination. Three of the four palliative care centers located in Nigeria between 2003-2006 were located in South-West Nigeria. For a country of 160 million people, this means that many people die without any access to palliative care.

The challenge was how to bring all the palliative care interest groups together under a single umbrella to form a national association. The first association failed because some people believed all members should be trained experts; this is contrary to my stand but it was a teething period. It was not until January 2007 that a newly registered national association, Hospice and Palliative Care Association of Nigeria (HPCAN) was inaugurated with the assistance of Dr. Anne Merriman. My greatest frustration was the lack of collegial cooperation in accessing a grant from the International Association of Hospice and Palliative Care (IAHPC) before the grant expiry date, to enable us to establish the West Africa Institute of Palliative Care at a prominent national University.

Navigating the Barriers

It was not easy to work together as a national team. Different people had diverse interests and little or no experience in running a state-wide association. Strategic planning was ineffective. At the third Annual General Meeting (2010) and Scientific Meeting of the Hospice and Palliative Care Association of Nigeria (HPCAN), I shared the knowledge I gained during the LDI program in November 2010.

I presented a situation analysis of palliative care in Nigeria compared with other African countries, reflecting the diverse level of palliative care achievement in Africa.

Recently at the fourth AGM/HPCAN Conference in June 2011, I presented a paper on ***"How to be an effective leader"*** using my experiences and sharing the curriculum from the International Palliative Care Leadership Development Initiative (LDI). The paper presentation was timely, emphasizing the importance of all members speaking with "one voice" and becoming more focused. This became even more relevant as most of the earlier foundation members were losing commitment. I also advised that incoming leaders should form close associations with health government officials. I stressed the need to acquire strategic planning skills and if possible liaise with LDI regarding some of its curriculum. Many of the participants agreed with my submissions and acknowledged the need for the association to go back to the drawing board and re-model the way.

I pointed out the benefits of LDI training, and strongly recommended that the physician members apply for the second cohort. I also encouraged other members to regard themselves as leaders in their respective hospitals and continue to champion the cause of palliative care. This was a moment of great personal satisfaction. As an LDI participant, I had been given the opportunity to share my LDI experiences and encourage members at the national level to join the process. The participants thanked me for sharing and asked several questions some of which included, "How do we speak with one voice? How do we influence health ministry officials and incorporate palliative care into national health policy? How do we ensure palliative care education and national standards?"

Leadership Journey (2010-2011)

The LDI opportunity came to me as a godsend. Such training is not available in my country and it is very costly to attend leadership courses elsewhere. The LDI team, mentors, faculty and consultants were phenomenal; these are leaders with integrity and a wealth of experience. I was guided to design my Individual Development Plan (IDP) which comprised the leadership skills that I wanted to develop over the two-year period. These include:

Palliative Care Activities Leadership Skills	
Presentation skills	Facilitating skills
Research methodology skills	Media skills

Manuscript writing skills	Event organization skill
Grant writing skills	Project strategic planning and implementation

Scaling-Up My Routine Palliative Care Services to Patients and Improving My Circle of Influence within the Centre (Advocacy and Training)

The first LDI residential course (January 2010) gave me courage to carry out my services with the self-confidence of a leader saddled with the responsibility of modeling the way. It was a great boost, because my palliative care project was stalled at this point. I had no further ideas to strategize and scale it up. I came back home armed with my IDP portfolio and strategies, but more determined than ever to build a multi-disciplinary team. I needed to review and improve my ability to influence my colleagues to embrace palliative care. One important lesson I learned at the first residential course was how to explore my circle of influence, negotiate and network with others. Another key lesson was how to manage the process of change.

My new strategy was to build an effective multi-disciplinary palliative care team. For the first time, I saw myself as a team leader. I emphasized the collective responsibility for planning and making decisions. Sharing the burden of developing the palliative care services lifted a lot of pressure from my shoulders. Together we organized several interactive seminars to facilitate collaboration with other hospital departments.

Challenges

The rising profile of palliative care brought fresh challenges. The hospital management claimed they wanted to do more but there was no provision in the formal budget to assist the project. They argued that lack of a national palliative care policy made it difficult to allocate budget to the service. Some colleagues still refused to refer their patients for palliative care.

Nevertheless, we continued to promote palliative care and gradually the number of referrals began to increase -- especially from the Renal Unit and sister hospitals. Unfortunately, some core team members found it difficult to make time for palliative care activities, complaining of conflict with their primary hospital assignment.

Palliative Care Staff Development and Training

In January 2011, we had an interactive workshop on Spiritual Care and Support in End-of-Life Care. About 140 health professionals and religious leaders attended the workshop. The Seminar allowed us to commission the participating Spiritual Care leaders as volunteers, which further extended our circle of influence in the community.

Our UK faculty partners were complemented by the local palliative care faculty of four members -- all of whom had completed postgraduate training in palliative medicine at the University of Cape Town under the tutelage of Dr. Liz Gwyther. I have this vision that local faculty will ultimately be part of the future palliative care trainer and faculty in Nigeria. Some 50 health professionals were trained and certificated during the one-week training.

General Public

In terms of community palliative care activities, HIV/AIDS and palliative care seminars were organized for Police Officers Women Association (POWA). The Prison Warden and I participated in television interviews on the importance of holistic End-of-Life care.

Assisting Other Hospitals to develop Palliative Care Services and Staff Development

A number of staff at other sister hospitals including Nursing and Midwifery Tutors participated in this education and training. We had follow-up visits with their management teams, encouraging them and offering assistance in establishing their own palliative care services. Since then we have received invitations to lead day seminars or participate in palliative care Grand Rounds in some of these centers. In February 2011, I was invited by the Head of Pain and Palliative Care at the University of Ilorin Teaching Hospital to participate in their three day staff training course.

Presentation, Facilitating and Event Organization

These three skills are crucial for a palliative care leader. In addition to organizing palliative care education and training events in my Centre, I also used the opportunity to develop presentation and facilitation skills.

Research Methodology, Manuscript and Grant Writing Skills acquisition

These skills are very vital to leadership success but not readily acquired. These are part of my IDPs and I needed to identify local teachers and mentors who can assist and impact these skills. The strategy was to train me and extend the benefit to my hospital community leaders by generating a multiplier effect and empowering them, too. The training was over-subscribed, so the number of participants had to be limited to 45 hospital consultants and chief residents. The faculty spent four days at this, and one member was amazed at the ingenuity of putting research methodology, manuscript and grant-writing skills together professionally. He promised to introduce the concept to the West African College of Physician and Surgeon Faculties.

Taking a cue from LDI procedures, all the lectures and presentations were compiled on discs/DVDs for future reference. Early this year, the hospital management appointed me as committee chairman to strategize the 2011 training events

Project Strategic Planning and Implementation

This was part of the second LDI residential curriculum, and on my return the experience I acquired proved to be quite valuable. The hospital management recently approved an old but refurbished building for our Day Care Hospice project. We needed a project development strategy and implementation exercises to involve the entire team. Although most members lacked the skills, I was able to facilitate the activities by mentoring others. Our project vision, mission and values were jointly designed by the team, which offered us a collective sense of ownership. The set values have become a guideline and liturgy for us all.

Media Skills

One of the practical features in the LDI training involves developing media presentational skills, as exemplified by Professor Emeritus Ron-Cameron Lewis. However, there are specific challenges for

me in practicing those skills here in Nigeria, as print media, radio and television stations are fully privatized. Accessing media requires paying for time or space. Nevertheless, I had three successful palliative care discussions with the public using the local TV facility, and I often meet people who make reference to these programs.

Lessons Learned

The LDI training has no doubt equipped me with the skills and knowledge to be an improved leader far better than where I was in 2009. Nevertheless, I do evaluate myself and also request feed-back from the team. I cannot proudly beat my chest that I have safely arrived at an expected finishing line but there is no doubt that I have improved measurably.

The team sets values that serve as guiding tenets for us all, providing checks and balances. I remember that it took the team several weeks to strategize on the theme for our palliative care Grand Round and we never arrived at a conclusion. It was then that I realized that democracy is good in politics to carry people along with you in becoming a leader, but at times democracy may slow the pace in making strong decisions. Thus, on a particular day I took the initiative and decided to act like the real boss and to model the way.

Palliative Care Project before LDI	Palliative Care Project after LDI
• Hospital community regarded the palliative care as Oyebola's pet project • Two Physicians work in full-time position • Limited Home-based Palliative Care services • No Spiritual support group • Never celebrated World Hospice and Palliative Care Day • No significant community outreach • Day Care Hospice Unit Proposal submitted to hospital management four years ago without any response • UK partners assisted us in a week-long training of 15 Nurses in 2008	• LDI Training empowered me to raise a strong vibrant interdisciplinary palliative care Team • Three Physicians and two full-time Nursing sisters with retired Chief Nursing officers as volunteers • Multidisciplinary Home-based Team including Christians and Muslim group now visit patients with us at home • Celebrated 2010 World Hospice and Palliative Care Day with PC multidisciplinary team • Palliative Care Community Outreach to Police Officers Wives and Prison Motherless/Juvenile Remand Homes • Bereavement care for the families of deceased patients • Formal approval and allocation of a temporary building for Day Care Unit • 1n 2011, 50 multi –professional teams were trained in both Basic and Advanced palliative care in 2-parallel sessions by UK Partners • Day-long seminar on spiritual care and support in End-of-Life Care for Spiritual care leaders and health care professionals to raise a team of Volunteers • A four-member team of local PC faculty was raised to assist the UK team with training • Step-down palliative care training to about 350

	hospital nursing staff created a multiplier effect

Challenges remain, including some team members who are reluctant to participate fully. Why do they stand at the doorway and obstruct others from coming in and joining the team? In the spirit of good leadership, I tried several times to discourage them from “sitting on the fence” and invited them in.

After much introspection, I decided to leave them to their ways. It occurred to me this could be deliberate -- an attempt to turn back the clock -- and I should not waste valuable time and energy running after them. Instead, I should focus on strategy and efforts to scale-up the project.

Nevertheless I am still in conflict but feel I have come a long way on this leadership trip -- with some modest achievements and a measurable positive learning curve.

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[i] Twelfth Night by William Shakespeare (1602)

[ii] New King James Version, Luke 4 verse 24