Suggestions for Response to 9/28/15 NYT article "A New Effort Has Doctors Turn Patients into Donors"

The NY Times, on September 28, 2015, published the article "A New Effort Has Doctors Turn Patients into Donors." The article is a result of a recent study published in the *Journal of Clinical Oncology*, by Dr. Reshma Jagsi, a Radiation Oncologist and Ethicist at the University of Michigan. We've attached both the article and the journal abstract to this note.

We could not be more excited the medical community is talking about the importance of philanthropy, and the role physicians have in a patient's decision to give. As you will see, in both the article and the abstract, Dr. Jagsi is interested in exploring how physicians should be involved in philanthropy. She surveyed 400 oncologists from leading cancer centers. *The New York Times* article focuses on the ethical side of physician involvement, and shares statistics on physician involvement from her study:

- half said they had been taught to identify wealthy patients,
- a third had been asked to directly solicit their patients, and
- three percent had been promised payments if a patient donated.

In her research abstract, there are other interesting statistics that were not shared in the NYT article:

- 77% of physicians in the study think patients feel empowered by donating
- 74% think physicians can make a unique contribution by participating in philanthropy
- 77% of physicians think it is their duty to participate in fundraising for the disease(s) they treat
- 58% feel a duty to fundraise for their institution
- 58% feel it is appropriate for a physician to initiate a discussion with his/her own patients about donating to his/her institution (at least in some circumstances).

Dr. Jagsi noted the common concerns physicians have with philanthropy – a patient's privacy, perception of providing special treatment for donors, the integrity of the physician/patient relationship, use of the money, etc. She also noted the importance of philanthropy to medical centers, and the high levels of gratitude that patients can feel as a result of the care they receive. Her research does not provide any conclusions, only that more discussion is needed on the topic.

The NYT article and Dr. Jagsi's research reminds us how important it is to build a program that stresses the importance of gratitude - not wealth, and the importance of operationalizing a program with consistent and transparent contact between the development office and clinicians.

Talking Points:

You may be asked by physicians and others for your response to this article or research. Below we have provided some talking points for your consideration.

1. Most important, a physician's involvement in a patient or family's decision to give is about honoring that patient or family's gratitude; it is not about money. Whether it is $1.00 or $1 million dollars, expressing gratitude allows patients and their families to say thank you to those who cared for them.
2. Grateful patient philanthropy programs are a continuation of the patient's clinical experience, and an extension of the patient's healing journey. Consequently, meaningful engagement of the clinical staff is not only ethical, it is critical.
3. Patients and families are grateful for the high-quality care and compassion and clinical excellence they receive from physicians, nurses and other hospital employees.
4. Patients and families are motivated to express this gratitude through philanthropy to say thank you for the care and compassion. They want to make a difference; they want to take back control of important decisions. They want to maintain relationships with clinicians. The want to bring closure to a challenging situation, or make something good out of something bad, particularly when a family member passes away.
5. <u>You are not asking a physician to think about money, only the extent of a patient or family's gratitude</u>.
6. When a patient or family is grateful and expresses an interest in helping, physicians have an opportunity to, in fact, help these patients and families. For many patients and families, giving back can become a part of their healing process.
7. Many clinical studies have shown the relationship between gratitude and healing. Expressions of gratitude have been linked to an increased ability to cope with stress, a stronger immune function, quicker recovery from illness, lower blood pressure, increased feelings of connectedness which improves relationships and well-being, greater joy, optimism and increased generosity and compassion. (See attached our white paper on the "Healing Power of Philanthropy").
8. By telling patients or families they don't have to do anything, physicians are, unintentionally, dismissing a patient or family's desire and in some cases - need - to give back and potentially harming their recovery, because of the guilt they will feel by not giving back.
9. <u>You are not asking physicians, and will never ask them, to solicit their patients for money</u>. You are asking physicians to, first, respond to a patient or family's expression of gratitude in a way that is helpful to the patient or family. And second, when a patient or family expresses an interest in helping you or the hospital, do not solicit them but simply thank them for their interest in helping and refer them to the philanthropy office. Finally, understand that a patient and family's motivation to give is because of the care and compassion you and your team provided, and as a result, the more you are involved in the process, the more meaningful the gift will be to the patient or family. Again, you never have to solicit, but there is nothing wrong or unethical for you to be involved in a way that's comfortable to you.

Other Points to Remember:

- Most clinicians and hospital employees believe that philanthropy is just about soliciting patients for money, and ultimately, is a financial transaction. Our internal research shows that more than 80 percent of clinicians and hospital employees do not want to be involved in philanthropy as a result of this perception.
- Patients and families who have had a meaningful philanthropic experience, believe that philanthropy is a transformational experience with the power to heal. There is nothing transactional about their motivation to give or the impact giving has on them. There are some great examples of grateful families included in the New York Times article.
- You are not promising money and certainly not providing payments to clinicians participating in this program. The donor decides where their gift will benefit the hospital or clinician.

Final Thought:

Nothing captures this entire conversation better than this video from Dr. Henry Kaminksi from George Washington Medicine. Please feel free to share with your physicians and colleagues.

https://youtu.be/bu5LPoeTzXs

The New York Times | http://nyti.ms/1VjtQPa

HEALTH

A New Effort Has Doctors Turn Patients Into Donors

By **GINA KOLATA** SEPT. 28, 2015

A well-to-do cancer patient is nearing the end of her treatments. During an office visit, she says to her doctor, “I can’t thank you enough for the care you provided.”

Should the doctor simply accept the patient’s gratitude — or gently suggest a way for her to show it: “Perhaps you might consider making a donation?”

More and more these days, development offices at major cancer centers are teaching doctors to seize such opportunities to raise money for the medical center or for their own research.

In an unprecedented survey of more than 400 oncologists at 40 leading cancer centers, nearly half said they had been taught to identify wealthy patients who might be prospective donors. A third had been asked to directly solicit donations — and half of them refused. Three percent had been promised payments if a patient donated.

The study, which was published online Monday in The Journal of Clinical Oncology, was conducted by Dr. Reshma Jagsi, a radiation oncologist and ethicist at the University of Michigan, who had grown concerned about the practice and wanted to know more.

Dr. Jagsi said she had sat in on workshops, seminars, training sessions and department meetings that discussed how to identify good prospects for gifts, how to direct grateful patients to the development office, and how to ask them directly if they wanted to donate.

She was uncomfortable with the idea, but she also knew some patients want to donate and are grateful for guidance on how to do it. And she knew medical centers needed money now more than ever. What was the ethical way for doctors to help, she wondered? Or should they stay out of the donation business completely?

She searched the medical literature for studies on the subject and found pretty much nothing, so she decided to conduct her own research.

The issue is "extraordinarily important," said Arthur L. Caplan, head of the division of medical ethics at NYU Langone Medical Center, adding that he had never seen a paper that examined the issues as thoroughly as Dr. Jagsi's. "Hopefully, this paper will start a long overdue discussion," he said.

He ticked off some ethical pitfalls: "Patients may be emotionally vulnerable; doctors have very close ties to their patients, which can strain asking on both sides; and the fact that incentives to ask sometimes skew toward the doctor's own program rather than the most needy areas of the hospital."

Yet, the practice of doctors soliciting donations from patients "is something that is happening and all signs are that it is going to continue and that it will increase," said Dr. Joseph A. Carrese, a primary care doctor and bioethicist at Johns Hopkins.

Patient donations, he added, are "an important source of resources when money is tight."

Dr. Carrese was concerned enough to join his colleagues in conducting an

interview study of Hopkins doctors. He said he was reassured that the physicians recognized the ethical tightrope they were on. But some, he said, admitted to giving big donors special treatment.

"I'm more likely to arrange a special appointment time for those patients so we are not rushed," one doctor who was interviewed for the study said. Another said, "I'm asking them to go above and beyond their relationship with me as a patient so I feel like I have to go above and beyond."

Different medical centers have different policies. At the Harvard Dana-Farber Cancer Institute, the goal is to leave the doctor out of the equation, said the president and chief executive, Dr. Edward J. Benz Jr. If a patient asks how to donate, the doctor is supposed to direct the patient to the development office. At one point, administrators considered giving patients brochures on how to donate when their treatment ended, but then decided that would be inappropriate.

At the University of North Carolina, said Dr. Norman E. Sharpless, director of the Lineberger Comprehensive Cancer Center, oncologists are advised not to directly solicit patients but to notify a development officer when a patient seems able and willing to make a donation.

He explained how it often works: "A patient with financial capacity expresses an interest in helping. The doctor tells a development officer, who invites the patient and doctor to lunch. "When it comes time to discuss a donation, the doctor gets out of the way."

Dr. Sharpless said he has never seen people get special care because they are rich, but added that there are subtle advantages that can accrue to donors. "If you are a prospective donor, or a donor, the development people can visit you at your home, can take you to lunch. If you are having a problem, your Rolodex at U.N.C. is bigger. You can reach out to the development officer and say, 'I am having a problem.'"

For Tom and Nancy Chewning of Richmond, Va., the path to donation began when their daughter received what they considered extraordinary care at the Lineberger Center. On their own they made a generous gift in honor of their daughter's oncologist, Lisa Carey. Then the development office asked if they might want to meet with Dr. Carey and discuss her needs.

So Mr. and Mrs. Chewning drove to Chapel Hill and sat down with Dr. Carey. When they asked what she needed, she said she could use money for her research and for helping patients, but she did not directly ask the Chewnings to contribute.

"I'm not very good at this," Dr. Carey said. Then Mr. Chewning asked her if she thought they could make a difference with a donation. He and his wife went home and made an even more generous donation, 10 times the original amount.

"It is something that says, 'I appreciate what you do,' " Mr. Chewning said. "I know it will be well spent."

Jack Hyer and his wife, Laura Jensen, who live just outside Chapel Hill, both were treated for cancer at the University of North Carolina and were so grateful for the care they received that they reconsidered their initial impulse to donate money to the university for athletic scholarships. After meeting with the head of the cancer center they ended up allocating about $2 million for research and for an endowed professorship in radiology.

"We committed our entire estate," Mr. Hyer said.

And Mr. Hyer made a training video for doctors to learn how to effectively ask for donations.

"The video sort of alerted them to be aware of the role they might play in identifying someone who might want to give," Ms. Jensen said.

"They show that film regularly," Mr. Hyer added.

A version of this article appears in print on September 29, 2015, on page A12 of the New York edition with the headline: A New Effort Has Doctors Turn Patients Into Donors.

JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

Oncologists' Experiences and Attitudes About Their Role in Philanthropy and Soliciting Donations From Grateful Patients

Jennifer K. Walter, Kent A. Griffith, and Reshma Jagsi

Jennifer K. Walter, University of Pennsylvania, Philadelphia, PA; and Kent A. Griffith and Reshma Jagsi, University of Michigan, Ann Arbor, MI.

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Corresponding author: Reshma Jagsi, Department of Radiation Oncology, University of Michigan, UHB2C490, SPC 5010, 1500 E Medical Center Dr, Ann Arbor, MI 48109-5010; e-mail: rjagsi@med.umich.edu.

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ABSTRACT

Purpose
Physician participation in philanthropy is important to marshal resources that allow hospitals to pursue their missions, but little is known about how physicians participate and their attitudes toward participation.

Methods
To characterize philanthropic roles physicians play and their attitudes about participation and its ethical acceptability, medical oncologists affiliated with the 40 National Cancer Institute–designated comprehensive cancer centers were randomly sampled and surveyed to evaluate experiences and attitudes regarding participation in philanthropy at their institutions. Responses were tabulated; significant associations by physicians' characteristics were explored.

Results
A total of 405 (52%) physicians responded; 62% were men, and 72% were white. Most (71%) had been exposed to their institution's fundraising/development staff; 48% of those were taught how to identify patients who would be good donors; 26% received information about ethical guidelines for soliciting donations from their patients; 21% were taught how their institution ensures Health Insurance Portability and Accountability Act compliance. A third (32%) of respondents had been asked to directly solicit a donation from their patients for their institution, of whom half declined to do so. Those who had solicited from their patients had been in practice significantly longer (mean, 19 *v* 13 years; $P < .001$). A substantial minority (37%) felt comfortable talking to their patients about donation (men more than women, 43% *v* 26%; $P = .008$); however, 74% agreed it could interfere with the physician-patient relationship, and 52% believe conflict of interest exists.

Conclusion
Institutions are asking physicians to directly solicit their patients for donations with variability in physicians' perceptions of the impact on relationships with patients and responses toward those requests.

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INTRODUCTION

Hospitals and medical centers are in need of new funding sources given decreases in governmental research funds and lowering reimbursement for clinical care.[1-3] Philanthropy is perceived to be essential in ensuring that hospitals and academic research can be adequately funded. Philanthropic contributions to academic medical centers increased 16.2% in 2013.[4] Donations from grateful patients made up approximately 20% of all philanthropic contributions to health care centers, totaling nearly $1 billion in 2009.[5] Grateful patient contributions are such an important source of revenue; not only do many articles exist on effective techniques for recruiting grateful patients in the development literature,[6-12] but clinical trials are being done to identify the most effective strategy to encourage physician participation in grateful patient fundraising.[13]

Physicians are an important resource in identifying and soliciting donations from grateful patients, largely because of their close relationship with potential donors.[14,15] Their participation has been shown to increase the frequency and size of these donations.[13,16] The development literature describes programs directed at physicians to encourage their participation,[6,11] but there are currently no data describing how prevalent these training programs are and what they include. There are also no data on physicians' perceptions of being asked to participate in development efforts, particularly with

respect to making requests of previous or current patients, and what development activities they have chosen to do.

Ethical concerns have been raised about the impact of physicians soliciting their own patients for donations on patient confidentiality and the physician-patient relationship.[17,18] Patients may feel unduly influenced to donate when asked by their own physicians, who have powerful influence on the care they receive. In addition, physicians may experience a conflict of interests when asked to honor their obligation to serve their patients and the obligation to raise funds for the institution. However, there are no empirical data on whether physicians perceive an impact on the relationship and whether they are concerned about its ethical acceptability. In addition, there has been little empirical exploration of services offered to donors or potential donors in return.

The objective of this study was to describe the experiences and attitudes of medical oncologists about their exposure to and participation in philanthropy at their comprehensive cancer centers. Our primary hypothesis was that a nontrivial proportion of oncologists would report having solicited their own patients for donations. We also sought to determine if respondent characteristics were associated with behaviors and attitudes. We specifically hypothesized that physicians' behaviors and attitudes would vary by gender, because women may be more likely to highlight the impact of moral choices on their relationships with others and, thus, perhaps more sensitive to how discussions of donation would affect their relationship with their patients.[19] We also hypothesized that behaviors and attitudes might vary by years of experience, time spent in clinical practice, or cancer center characteristics. Finally, we sought to characterize the services that respondents believed were offered to donors or potential donors at these cancer centers.

METHODS

This cross-sectional study of medical oncologists was approved by the institutional review board at the University of Michigan (Ann Arbor, MI).

Study Sample

The study sample included medical oncologists practicing at the 40 National Cancer Institute–designated Comprehensive Cancer Centers that treat adult patients in 2012 (Appendix, online only). Subjects were chosen at random from a list assembled by Internet searching the Web sites of these institutions to identify all physicians listed as practicing medical oncology at these centers, who were then sent a postal questionnaire. Oncologists were chosen as subjects because they have a longitudinal relationship with patients who confront life-threatening illnesses, and they previously have been included in research on increasing grateful patient solicitation by physicians.[13]

Because our primary objective was to conduct descriptive analyses, our sampling approach was defined after pragmatic consideration of funding available for incentives and the desire to ensure that our estimates would have sufficient precision to be informative while also minimizing generalizability concerns related to survey nonresponse. On the basis of prior experience, we believed we could attain a response rate of 50% if administering $20 incentives[20-22] with a postal questionnaire to oncologists. Given the budget available for incentives, we were able to administer $20 incentives to a simple random sample (each medical oncologist on our list having 50% probability of selection), which we expected to result in approximately 400 responses. With this sample size, we expected adequate power (80%) to detect gender differences of reasonable magnitude (15% difference in a binary outcome).

Survey Design and Administration

A print survey was mailed to 771 medical oncologists at their cancer center up to two times with $20 cash included in the first mailing only as an incentive to complete the survey, as well as a third e-mail reminder to nonrespondents. The survey was developed using standard techniques of questionnaire design, including literature review and discussion with experts for definition of key constructs, followed by detailed cognitive pretesting to improve the validity of the measures.[23,24]

Measures

The final questionnaire (Data Supplement) collected information about subjects, including time in practice (categorized for analysis as ≤ 5, 6 to 11, 12 to 20, or 21+ years), percentage of working time spent in clinical practice (categorized for analysis as $\leq 30\%$, 31% to 70%, and 70%+), gender, and race (categorized for analysis as white or other). Subjects were asked about when and how they were exposed to fundraising staff at their institution, how often they have contact with staff, and what subjects were covered in trainings or individual sessions. The survey asked about subjects' experience with several different kinds of activities, including "joining a fundraising committee," "displaying fundraising or development information in the waiting room," "referring names of patients who would be potential donors to the development office," and "directly asking my patients for donations." The responses to these questions were as follows: "I have done this," "I have been asked but didn't do this," and "I haven't been asked." Subjects were surveyed about their attitudes related to participation in philanthropy by asking them to rate their agreement or disagreement with statements on a four-point Likert scale (strongly disagree to strongly agree, dichotomized for analysis). Finally, respondents were asked about services that they believed were provided to patients who donated or are potential donors within their institution, including additional opportunities for contact with providers, expedited clinical visits, fast-track in the emergency department, or nicer inpatient rooms.

In addition to these self-reported measures, cancer centers were divided into quartiles on the basis of amount of National Cancer Institute core grant funding, as determined through Internet searching.

Statistical Analyses

First, we compared respondents with nonrespondents for the two variables we were able to determine for all individuals in the target population on the basis of publicly available information: cancer center core grant size and gender. Second, we described the study sample and then self-reported exposure to different forms of fundraising or development activities and staff. Third, we described respondents' experiences with different fundraising activities and behaviors. The primary outcome of interest among these experiences had been designated a priori as having solicited one's own patients for donations. Therefore, we proceeded to conduct bivariate and then multivariable logistic regression to describe associations between this primary outcome variable and those respondent characteristics that we hypothesized might influence this behavior (gender, race, years in practice, percentage of clinical time, and size of cancer center core grant). Fourth, we described attitudes toward development activities by gender, which was the primary independent variable of interest, and provided P values from multivariable analyses that adjusted for years in practice, percentage of clinical time, race, and cancer center core grant size. Because readers might also want to see the full results of the multivariable models of each of the attitudes to evaluate the extent to which specific attitudes might differ by years in practice, percentage of clinical time, race, and cancer center core grant size, we also summarized the full model results for each attitude (Appendix Table A1, online only).

Finally, we described responses regarding services provided to donors or potential donors at respondents' institutions. To determine how prevalent these practices were, descriptive statistics were also reported by the number of unique institutions represented by respondents who endorsed each service. For all statistical tests, $P \leq .05$ was considered significant.

Table 1. Sample Characteristics of Medical Oncologists Surveyed About Experiences With Development (N = 405)

Characteristic	No. (%)
Gender	
Female	147 (36.3)
Male	252 (62.2)
Not reported	6 (1.5)
Race/ethnicity	
White	283 (69.9)
Other	108 (26.7)
Black	11 (2.7)
Hispanic/Latino	9 (2.2)
Arab-American	5 (1.2)
Native American/Alaska Native	1 (0.3)
Asian/Pacific Islander	82 (20.3)
Not reported	14 (3.5)
Cancer center by core grant size, percentile	
≤ 25	154 (38.0)
26-50	104 (25.7)
51-75	83 (20.5)
76-100	64 (15.8)
Time in practice, years	
Mean (SD) [minimum-maximum]	13.8 (10.7) [1-53]
≤ 5	111 (27.4)
6-11	96 (23.7)
12-20	97 (24.0)
21+	96 (23.7)
Not reported	5 (1.2)
% of clinical time	
≤ 30	117 (28.9)
31-70	214 (52.8)
71+	71 (17.5)
Not reported	3 (0.7)

Table 2. Respondent Exposure to Fundraising/Development Staff

Exposure	No. (%)
Have you ever been exposed to the fundraising/development staff?	288 (71)
Of those with exposure (n = 288)*	
They contacted me personally	228 (79)
I contacted them to discuss a patient	117 (41)
They spoke at a meeting I attended	107 (37)
I attended a training session	42 (15)
Frequency of exposure (n = 288)	
One time a year or less	72 (25)
Few times a year	161 (56)
Monthly	35 (12)
More than monthly	18 (6)
Not reported	2 (1)
Content discussed during exposure (n = 288)*	
Importance of philanthropy to institution's success	207 (72)
Importance of physician participation in philanthropy	186 (65)
How to identify patients who would be good donors	138 (48)
Ethical guidelines about soliciting donations from own patients	74 (26)
How to ensure HIPAA regulations are followed in this process	59 (20)

Abbreviation: HIPAA, Health Insurance Portability and Accountability Act.
*Not mutually exclusive groups; all options that applied were reported.

RESULTS

Sample Characteristics

Of the 771 medical oncologists who were mailed the survey, 405 (52.5%) responded. The size of the respondents' cancer center core grant was similar to that of nonrespondents ($P = .17$); however, the proportion of female physicians was significantly higher among respondents than among nonrespondents (36.3% *v* 30.3%; $P = .05$). Most respondents were white (69.9%) and male (62.2%; Table 1).

Exposure to Fundraising/Development Staff

Overall, 71% of all respondents reported having been exposed to fundraising or development staff. The nature of these exposures varied, with most having been contacted personally by development staff (79%) and 41% having contacted development staff themselves about a patient they had cared for (Table 2). Of respondents, 37% reported feeling that they were being asked to work with development staff more frequently than in the past and 35% indicated they were more comfortable working with staff now than they had been in the past. Most respondents reported that the content of these contacts, which may have occurred during a designated training or in individual sessions, included discussion of the importance of physician participation in philanthropy and importance of philanthropy to the institution. Approximately half were taught how to identify patients who would be good donors, whereas fewer than a third stated that these experiences included pragmatic ethical guidance about soliciting donations or ensuring that Health Insurance Portability and Accountability Act regulations were followed (Table 2).

Experiences With Fundraising Roles

Respondents described a variety of philanthropic activities that they had been asked to participate in, with small percentages reporting refusing to participate in some activities (Table 3). Of respondents, 51% stated they had been asked to refer names of their patients who may be potential donors to the development office, with 37% reporting having done this. Of respondents, 32% stated they had been asked to directly solicit a donation from their patient for their institution, with half of those physicians reporting that they declined to do so. A small minority (3%) described being offered a financial incentive to encourage them to solicit donations from their own patients.

In bivariate analysis, increased years in practice and male gender were associated with increased likelihood of soliciting donations from patients. In adjusted analysis controlling for race, percentage of working time devoted to patient care, and size of cancer center core grant, physicians in practice greater than 20 years had significantly higher likelihood than those who have been in practice less than 5 years to directly solicit donations from patients (adjusted odds ratio, 6.10; 95% CI, 2.39 to 15.61; $P < .001$), with a trend of men being more likely to solicit donations than women (adjusted odds ratio, 1.94; 95% CI, 0.97 to 3.85; $P = .06$; Table 4).

Attitudes About Fundraising Activities

Most (77%) of respondents felt a duty to participate in fundraising for the disease or diseases they treat; fewer (58%) felt a duty

Table 3. Responding Oncologists' Behaviors and Experience With Fundraising Activities

Activity	No. (%)		
	I Have Done This	I Have Been Asked But Did Not Do This	I Have Not Been Asked
Joining a fundraising committee for my institution	43 (11)	9 (2)	344 (85)
Speaking at a public meeting about philanthropy to my institution	109 (27)	10 (3)	280 (69)
Signing a letter to my patient	69 (17)	15 (4)	312 (77)
Displaying fundraising or development information in the waiting room of my office	58 (14)	10 (2)	326 (80)
Referring names of patients who would be potential donors to the development office	151 (37)	55 (14)	192 (47)
Directly asking my patients for donations to my institution	65 (16)	63 (16)	266 (66)

to participate for their institutions. Respondents believed that physicians make a unique contribution to the fundraising effort (74%) and that patients feel empowered by donating (77%; Table 5). However, 73% worried that talking with their patients about donating to the institution may interfere with the physician-patient relationship, with 62% describing a potential conflict of interest when directly soliciting a donation from a grateful patient. Overall, 37% were comfortable talking with their patients about donating to their institution, with males significantly more likely to express comfort than females (43% *v* 26%; $P = .01$) when controlling for years in practice, percentage clinical time, race, and core grant size (Table 5). Although 15% of all respondents expressed there would be negative consequences if they refused participation in philanthropy, females were significantly more likely to express this concern than males (20% *v* 12%; $P = .02$) when controlling for years in practice, percentage clinical time, race, and core grant size.

Services Provided to Donors or Potential Donors

When asked about what additional services might be provided to donors and potential donors, 33% of respondents affirmed that they believe that donors can be offered convenience-related services, whereas only 17% affirmed donors should receive those services (Table 5). Men were significantly more likely to endorse that donors should receive those services than women (21% *v* 10%; $P = .01$). Although 20% of respondents (from 33 unique institutions) believed that others in their institution provided additional opportunities to donors and potential donors for contact via personal e-mail or telephone numbers, only 7% stated that they themselves provided these things to donors. A total of 28% respondents (from 32 institutions) stated that they perceived that donors received expedited clinical visits at their institution, whereas 5% (from 18 institutions) believed donors received fast-tracking in the emergency department. Overall, 10% (from 23 institutions) believed that their institution offered nicer patient rooms for donors. In sum, respondents from 37 institutions responded affirmatively to at least one of these questions about special services for donors or potential donors.

DISCUSSION

Development teams argue that physicians play an essential role in ensuring institutions meet their fundraising goals and in providing an important opportunity to potential donors, who may benefit

Table 4. Association Between Asking Patients for Donation and Responding Oncologist Characteristics

Characteristics	Unadjusted OR (95% CI)	*P*	Adjusted OR (95% CI)	*P*
Time in practice (reference, ≤ 5), years				
6-11	1.97 (0.73 to 5.32)	.33	1.78 (0.64 to 4.92)	.27
12-20	3.78 (1.51 to 9.45)	.11	3.28 (1.27 to 8.49)	.01
> 20	5.93 (2.44 to 14.39)	< .001	6.10 (2.39 to 15.61)	< .001
% of working time devoted to patient care (reference, 31%-70%)				
≤ 30	1.24 (0.69 to 2.25)	.47	0.89 (0.47 to 1.71)	.72
> 70	0.68 (0.30 to 1.54)	.35	0.62 (0.26 to 1.50)	.29
Gender (reference, female)				
Male	2.53 (1.32 to 4.85)	.005	1.94 (0.97 to 3.85)	.06
Race (reference, white)				
Other	0.80 (0.43 to 1.51)	.49	1.33 (0.67 to 2.67)	.42
Size of cancer center core grant by quartiles (reference, quartile 1)				
2	0.77 (0.40 to 1.51)	.96	0.67 (0.32 to 1.37)	.27
3	0.58 (0.27 to 1.26)	.32	0.54 (0.24 to 1.24)	.14
4	0.76 (0.35 to 1.67)	.98	0.76 (0.31 to 1.86)	.55

Abbreviation: OR, odds ratio.

Table 5. Association Between Agreement With Attitudes Toward Development and Gender

Attitude	No. (%) Females (n = 147)	No. (%) Males (n = 252)	P*
Duty to participate in fundraising for my institution	76 (52)	155 (62)	.35
Duty to participate in fundraising for the disease(s) I treat	114 (78)	195 (77)	.57
I worry that talking to my patients about donations might interfere with the relationships I have with them	113 (77)	178 (71)	.11
I think physicians can make a unique contribution by participating in philanthropy	102 (69)	192 (76)	.98
I think patients feel empowered by donating	108 (74)	201 (80)	.74
I think patients who donate can be offered certain convenience-related services within the hospital as thanks without raising ethical concerns	41 (28)	89 (35)	.37
I think patients who donate should be offered certain convenience-related services within the hospital as thanks	14 (10)	53 (21)	.01
I worry there is a conflict of interest if I directly speak to my patients about making donations to my institution	95 (65)	153 (61)	.35
I feel comfortable talking to my patients about donating to my institution	39 (26)	107 (43)	.01
I believe there would be negative consequences for me if I refused to participate in philanthropy at my institution	29 (20)	29 (12)	.02
I feel it is appropriate in at least some circumstances for a physician to initiate a discussion with her own patients about donating to her institution	77 (52)	153 (61)	.45

*P value is adjusted after controlling for the physician's years in practice, race, and percentage of working time devoted to patient care, and the level of institutional funding as measured by the cancer center core grant (P30). See Appendix Table A1 for full model results for each attitude.

from the chance to exercise altruism and feel empowered by contributing to the broader fight against a disease that has afflicted themselves or a loved one. Therefore, the literature on hospital development includes description of the importance of programs to increase physician comfort and willingness to participate in philanthropy in a variety of roles. This study is the first, to our knowledge, to offer empirical data on what physicians are being asked by their institutions to do and what their attitudes are toward participation in philanthropy.

Our sample had overwhelmingly been exposed to development staff, with approximately half of them being taught about ways to identify potential donors. Development staff appear to have successfully conveyed their message to physicians that they played a unique role in philanthropy, and many felt institutional responsibility to do their part. Many respondents also voiced concerns about conflicts of interest, given their dual obligations to serve the individual patients before them and to support their institution's efforts to marshal resources. The frequency of these concerns suggests that further deliberation and explicit articulation of detailed ethical guidelines from professional societies, beyond the relatively vague and permissive standards that currently exist, might be useful.[17] Further research, including qualitative investigation, is warranted to understand more about how physicians balance these competing obligations to their institution and their patients.

Interviews with physicians at one institution who have self-described high levels of comfort with engaging their patients in discussion about philanthropy believe that this relationship begins with excellent patient care, which arguably all physicians strive to provide.[25] Interestingly, these physicians would rather solicit donations themselves rather than making a referral to development staff and turning over the process of solicitation to them, perhaps out of a concern for retaining control over solicited funds (and heightening the conflict of interest involved). Our sample of medical oncologists at comprehensive cancer centers expressed more reticence about approaching their own patients to solicit donations. Although 37% of physicians stated they are comfortable talking with their patients about donating to their institution, only 16% affirmed they have actually asked their own patients about donating to their institution. An additional 16% have been asked to solicit donations and have declined. We have noted significant differences in years in practice for willingness to solicit donations, which can be attributed to either the increasing comfort that physicians have making these requests over the years or perhaps generational changes in expectations in the relationship between physicians and patients. We had hypothesized that women would be more concerned about the impact of these conversations on their relationship with their patients, therefore more uncomfortable with having these conversations and less likely to solicit donations as a result. Our adjusted analyses demonstrated that women were more uncomfortable than men talking with their patients about making donations and less likely to solicit donations. However, women did not claim that they were significantly more worried that the request for donation would interfere with their relationships with their patients or that there was a potential conflict of interest in doing so. Our survey did not elucidate the explanation for this difference in comfort level, and further research is warranted to explore this issue further. Perhaps other factors, such as women's documented differences in asking for resources in other contexts, might play some role.[26,27]

We also observed that at least one respondent from almost every institution reported that additional services are offered to donors. The possibility that some donors may receive VIP services that extend beyond hoteling amenities and may also enhance access to medical care may further complicate the question of whether respondents perceive the ethical acceptability of soliciting donations from their patients.

Although this study has strengths, including its relatively novel focus and national sampling strategy, it also has limitations that merit note. The response rate was 53%. Although this response rate is higher than achieved in many other physician surveys, especially those of oncologists, it leaves open the possibility of selection bias because of nonresponse. It is possible that we may have only captured the attitudes of a segment of medical oncologists practicing in comprehensive

cancer centers, although we did obtain responses from individuals at every cancer center and did not observe systematic differences in the size of cancer center core grant between respondents and nonrespondents, so we did have reasonable representation of individuals across those institutions.

Philanthropy represents a major opportunity for cancer centers and hospitals to raise revenues at a time when traditional sources of funding are becoming less reliable, while also benefiting those patients who feel empowered by supporting the fight against cancer. Given that many oncologists report becoming increasingly engaged in philanthropic efforts and express varying attitudes in this context, careful attention is necessary to ensure that these activities are conducted in ways consistent with ethical norms and policies embraced by physicians, patients, and the general public.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Disclosures provided by the authors are available with this article at www.jco.org.

AUTHOR CONTRIBUTIONS

Conception and design: Jennifer K. Walter, Reshma Jagsi
Financial support: Jennifer K. Walter, Reshma Jagsi
Administrative support: Reshma Jagsi
Collection and assembly of data: Reshma Jagsi
Data analysis and interpretation: All authors
Manuscript writing: All authors
Final approval of manuscript: All authors

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Oncologists' Experiences and Attitudes About Their Role in Philanthropy and Soliciting Donations From Grateful Patients

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Reshma Jagsi
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Honoraria: *International Journal of Radiation Oncology Biology Physics*
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Appendix

The following is a list of National Cancer Institute–designated Comprehensive Cancer Centers included in this study: Memorial Sloan-Kettering Cancer Center (New York, NY); Dana-Farber/Harvard Cancer Center (Boston, MA); Fred Hutchinson/University of Washington Cancer Consortium (Seattle, WA); MD Anderson Cancer Center (Houston, TX); Fox Chase Cancer Center (Philadelphia, PA); Sidney Kimmel Comprehensive Cancer Center (Baltimore, MD); University of California San Francisco Helen Diller Family Comprehensive Center (San Francisco, CA); Abramson Cancer Center (Philadelphia, PA); University of North Carolina Lineberger Comprehensive Cancer Center (Chapel Hill, NC); University of Southern California Norris Comprehensive Cancer Center (Los Angeles, CA); Vanderbilt-Ingram Cancer Center (Nashville, TN); Duke University Cancer Center (Durham, NC); University of Alabama Birmingham Comprehensive Cancer Institute (Birmingham, AL); University of Michigan Comprehensive Cancer Center (Ann Arbor, MI); Mayo Clinic Cancer Center (Rochester, MN); Jonsson Comprehensive Cancer Center (Los Angeles, CA); University of Pittsburgh Cancer Institute (Pittsburgh, PA); Case Comprehensive Cancer Center (Cleveland, OH); Robert H. Lurie Comprehensive Cancer Center (Chicago, IL); University of Wisconsin Paul P. Carbone Comprehensive Cancer Center (Madison, WI); Alvin J. Siteman Cancer Center (St Louis, MO); Moores Comprehensive Cancer Center (San Diego, CA); University of Chicago Comprehensive Cancer Center (Chicago, IL); University of Colorado Cancer Center (Aurora, CO); Roswell Park Cancer Institute (Buffalo, NY); University of Arizona Cancer Center (Tucson, AZ); Herbert Irving Comprehensive Cancer Center (New York, NY); Comprehensive Cancer Center-James Cancer Hospital and Solove Research Institute (Columbus, OH); Masonic Cancer Center (Minneapolis, MN); Norris Cotton Cancer Center (Lebanon, NH); H. Lee Moffitt Cancer Center & Research Institute (Tampa, FL); Cancer Institute of New Jersey (New Brunswick, NJ); University of California Davis Comprehensive Cancer Center (Sacramento, CA); Barbara Ann Karmanos Cancer Institute (Detroit, MI); City of Hope Comprehensive Cancer Center (Duarte, CA); Yale Cancer Center (New Haven, CT); Holden Comprehensive Cancer Center (Iowa City, IA); Georgetown Lombardi Comprehensive Cancer Center (Washington, DC); Wake Forest Comprehensive Cancer Center (Winston-Salem, NC); and Chao Family Comprehensive Cancer Center (Orange, CA).

Table A1. Full Models of Measured Attitudes

Attitude*	Odds Ratios (95% CIs)					
	1	2	3	4	5	6
Time in practice (reference, ≤ 5), years						
6-11	1.07 (0.60 to 1.91)	1.07 (0.49 to 2.33)	0.80 (0.40 to 1.59)	0.93 (0.48 to 1.80)	1.06 (0.52 to 2.15)	1.21 (0.65 to 2.24)
12-20	1.20 (0.65 to 2.20)	0.67 (0.32 to 1.43)	1.20 (0.57 to 2.54)	0.73 (0.37 to 1.41)	1.33 (0.62 to 2.89)	1.44 (0.77 to 2.73)
> 20	1.28 (0.68 to 2.40)	0.67 (0.32 to 1.44)	0.38 (0.19 to 0.77)	2.37 (1.07 to 5.25)†	1.47 (0.66 to 3.26)	1.23 (0.64 to 2.39)
% of working time devoted to patient care (reference, 31%-70%)						
≤ 30	1.91 (1.14 to 3.20)†	1.12 (0.59 to 2.14)	0.98 (0.56 to 1.70)	1.67 (0.91 to 3.07)	1.43 (0.72 to 2.83)	1.03 (0.62 to 1.71)
> 70	0.69 (0.39 to 1.21)	0.33 (0.18 to 0.63)†	1.54 (0.76 to 3.15)	0.78 (0.41 to 1.48)	0.50 (0.26 to 0.95)†	0.64 (0.34 to 1.20)
Gender (reference, female)						
Male	1.24 (0.79 to 1.95)	0.85 (0.48 to 1.50)	0.64 (0.37 to 1.11)	0.99 (0.59 to 1.67)	1.10 (0.63 to 1.93)	1.25 (0.77 to 2.02)
Race (reference, white)						
Other	0.97 (0.59 to 1.59)	1.55 (0.80 to 3.01)	0.72 (0.41 to 1.27)	2.25 (1.21 to 4.18)†	1.25 (0.66 to 3.26)	1.46 (0.88 to 2.42)
Size of cancer center core grant by quartiles (reference, quartile 1)						
2	0.67 (0.39 to 1.14)	0.63 (0.33 to 1.22)	0.74 (0.41 to 1.35)	0.93 (0.49 to 1.75)	0.96 (0.47 to 1.98)	1.83 (1.06 to 3.18)†
3	1.16 (0.64 to 2.10)	0.80 (0.38 to 1.66)	1.16 (0.59 to 2.27)	0.61 (0.32 to 1.19)	0.60 (0.29 to 1.22)	1.62 (0.89 to 2.95)
4	0.65 (0.34 to 1.25)	0.73 (0.32 to 1.66)	1.31 (0.59 to 2.91)	0.64 (0.30 to 1.36)	0.69 (0.31 to 1.53)	0.92 (0.44 to 1.93)

Attitude*	7	8	9	10	11
Time in practice (reference, ≤ 5), years					
6-11	1.31 (0.59 to 2.93)	1.04 (0.57 to 1.90)	1.27 (0.69 to 2.33)	1.49 (0.66 to 3.34)	0.96 (0.54 to 1.70)
12-20	1.87 (0.83 to 4.22)	0.81 (0.44 to 1.49)	1.18 (0.62 to 2.21)	1.32 (0.56 to 3.12)	1.52 (0.83 to 2.77)
> 20	1.46 (0.62 to 3.45)	0.62 (0.33 to 1.16)	1.94 (1.03 to 3.66)†	1.05 (0.41 to 2.67)	1.69 (0.91 to 3.16)
% of working time devoted to patient care (reference, 31%-70%)					
≤ 30	0.86 (0.45 to 1.68)	1.18 (0.72 to 1.95)	1.31 (0.80 to 2.15)	0.75 (0.36 to 1.56)	1.02 (0.62 to 1.67)
> 70	1.24 (0.59 to 2.62)	1.22 (0.68 to 2.22)	0.67 (0.36 to 1.25)	0.94 (0.42 to 2.08)	0.60 (0.34 to 1.06)
Gender (reference, female)					
Male	2.37 (1.22 to 4.61)†	0.80 (0.51 to 1.28)	1.82 (1.13 to 2.93)†	0.48 (0.26 to 0.89)	1.19 (0.76 to 1.86)
Race (reference, white)					
Other	2.42 (1.30 to 4.51)†	0.74 (0.45 to 1.22)	1.69 (1.02 to 2.80)†	0.65 (0.32 to 1.36)	1.47 (0.89 to 2.43)
Size of cancer center core grant by quartiles (reference, quartile 1)					
2	2.07 (1.01 to 4.25)†	0.87 (0.51 to 1.49)	0.97 (0.56 to 1.68)	0.75 (0.34 to 1.66)	0.98 (0.57 to 1.67)
3	2.10 (0.99 to 4.46)	0.92 (0.51 to 1.65)	0.97 (0.54 to 1.75)	0.96 (0.43 to 2.16)	0.85 (0.48 to 1.51)
4	1.11 (0.43 to 2.88)	0.95 (0.49 to 1.87)	0.82 (0.41 to 1.64)	1.17 (0.48 to 2.86)	0.88 (0.45 to 1.69)

*Attitude question text: (1) I feel a duty to participate in fundraising for my institution; (2) I feel a duty to participate in fundraising for the disease(s) I treat; (3) I worry that talking to my patients about donations might interfere with the relationships I have with them; (4) I think physicians can make a unique contribution by participating in philanthropy; (5) I think patients feel empowered by donating; (6) I think patients who donate can be offered certain convenience-related services within the hospital as thanks without raising ethical concerns; (7) I think patients who donate should be offered certain convenience-related services within the hospital as thanks; (8) I worry that there is a conflict of interest if I directly speak to my patients about making donations to my institution; (9) I feel comfortable talking to my patients about donating to my institution; (10), I believe there would be negative consequences for me if I refused to participate in philanthropy for my institution; (11) I feel it is appropriate in at least some circumstances for a physician to initiate a discussion with her own patients about donating to her institution.

†$P \leq .05$.

THE HEALING POWER OF PHILANTHROPY

A GOBEL GROUP WHITE PAPER | 2014

Gobel Group | w: gobelgroup.com p: 585-598-1171 e: info@gobelgroup.com

The Gobel Group

Gobel Group is the leading healthcare philanthropic services firm that educates and engages physicians in the philanthropic process. As a result of its programs, hospitals have built robust grateful patient philanthropy programs with more engaged physicians, more prospects, more innovative funding priorities, more productive development officers and more philanthropic revenue. Clients are averaging a 10 to 1 return on their investment after just one year. Gobel is currently working with more than 100 hospitals, from large academic medical centers to independent community hospitals, across the country and around the world.

THE HEALING POWER OF PHILANTHROPY

A Gobel Group White Paper

Part of the Healing Process

Grateful patient philanthropy programs, as their name suggests, are a way for patients to express their gratitude through philanthropy to the physicians, nurses, and other caregivers. The donor's gratitude is in direct response to the high quality, clinical excellence and exceptional experience they have had in the course of their healthcare encounter (Stewart et al. 2011). These grateful patients have had the kind of care from providers every hospital and health system is working hard to achieve.

Grateful patients will often say to care providers, "What may seem ordinary to you is extraordinary to me. I feel so fortunate to have had such exceptional care." This patient gratitude and its resulting philanthropy are tangible outcomes of the myriad ways organizations are working to drive exceptional patient experience.

Gratitude is Good for Health

Clinical research provides compelling evidence that highlights the role of philanthropy in patient encounters. Expressions of gratitude, such as those made by a grateful patient, have been linked to an increased ability to cope with stress, a stronger immune function, quicker recovery from illness, lower blood pressure, increased feelings of connectedness which improves relationships and well-being, greater joy, optimism and increased generosity and compassion (Emmons 2010). In a review article published by Harvard Health Publications in November 2011, the authors put it quite succinctly "expressing thanks may be one of the simplest ways to feel better" (*The Harvard Mental Health Letter*, November 2011).

Happy Patients and Improved Health

When those expressions of gratitude are linked with a wish to make a philanthropic gift, it causes happiness. A study published in *Science* by Harvard Business School in 2008 showed spending money on others causes happiness more than spending on oneself (Dunn et al. 2008). People who participate in charitable giving are 43 percent more likely to report they are "very happy" than non-givers, while non-givers are three and a half times more likely than givers to report they are "not happy at all" (Brooks 2007). People who give and experience happiness are more likely to give again in the future, causing more happiness and making them more likely to give again, in a self-perpetuating cycle (Aknin et al. 2012).

Happiness has also been linked to good health. Beyond the immediate elevated mood experienced when people feel happy, happiness has been shown to add as much as nine years to life expectancy (Emmons 2007) and can reduce blood pressure and the risk of cardiovascular disease (Fredrickson 1998).

By understanding the healing benefits of philanthropy, clinicians can become comfortable with their participation in the philanthropic process.

Similarly, charitable giving has been linked to many physical health improvements including a stronger immune response, decreased levels of stress hormones, a quicker cardiovascular recovery from stress, increased long term survival in HIV/AIDS patients, decreased blood pressure, and decreased viral loads (Konrath 2013). The suggestion has also been made that charitable giving at high rates of frequency may protect patients from the on-set of new health issues when faced with a new stressor (Poulin et al. 2013). Finally, charitable giving was shown to reduce overall mortality rate in older adults by as much as 47 percent (Okun et al. 2013).

Creating a Culture of Gratitude

For decades, philanthropy programs have focused on the goal of creating a culture of philanthropy at hospitals. For most, this goal has not been attained. Frequently this is because clinicians, hospital leaders, and other hospital employees think about philanthropy as a financial transaction, not a transformative experience for patients. Based on a growing body of research, it is time to change this mindset and focus on the role of gratitude and giving back in the healing process. Institutions and individual clinicians who learn to think and behave differently towards grateful patients will help these patients to find meaning and purpose in their experiences.

Everyone whose work touches the patient must understand that their work has the potential to create gratitude for patients, and that this gratitude may spark a desire to make a gift.

That's why it is essential to create a grateful patient philanthropy program that is focused on building a **culture of gratitude** across the organization. Everyone whose work touches the patient must understand that their work has the potential to create gratitude for patients, and that this gratitude may find expression in a philanthropic gift. The key is to recognize, accept and welcome the gratitude being expressed and when a patient expresses an interest in giving back, to know how to refer that patient to the philanthropy office.

Hospital leaders talk about patient satisfaction and developing service recovery plans every day. But how much time are they spending teaching employees how to accept gratitude from patients? Usually, not very much. Yet, research shows that operationalizing a program to help clinicians and employees learn how to accept gratitude will likely improve patient satisfaction scores and could have a powerful impact on a patient's compliance with treatment. Such compliance will favor a reduction in readmission rates, among other benefits.

The relationship between the patient and their clinician is of the utmost importance. The philanthropy team supports this relationship by facilitating the expression of gratitude.

The Philanthropy office has an important role to play in creating and fostering a culture of gratitude. It is the job of the Philanthropy team to partner with physicians and clinicians to identify grateful patients and then, with the knowledge and participation of the referring physician or clinician, to engage the patient in a discussion of the patient's desire to make a gift. The relationship between the patient and their clinician is of the utmost importance. The philanthropy team supports this relationship by facilitating the expression of gratitude.

The goal of this effort is to systemize the process, conceptualize collateral materials, and provide the technological tools to make it seamless and comfortable for physicians to make referrals. Examples of tools philanthropy offices can use to make this engagement easy and efficient are:

- Smartphone apps for referral of patient names
- Built-in "orders" inside an organization's EMR
- Written and video physician champion "cases for support"
- Physician web landing pages
- Philanthropy officer referral cards and posters
- Customized letters, emails, phone and in-person scripts for physicians to use when introducing the philanthropy officer
- Grateful patient stories on video

The Philanthropy officer will partner with each physician and clinician to create a customized process based on best practices.

Benchmarks of a Successful Grateful Patient Program

- Research conducted by the Gobel Group finds the ideal ratio of Physician Champions per philanthropy officer is 10 to 1. Therefore, if a philanthropy office has 4 philanthropy officers, the team would want to identify 40 prospective physician champions. Once the list of prospective physician champions has been developed, it should be reviewed with key leadership. By engaging senior leaders in the vetting process, they will feel ownership over the list and program.

- Based upon work by the Gobel Group, after approximately six to twelve months of implementation, a hospital will see an average of two to four new patient names identified each month from each physician. If your philanthropy program has four philanthropy officers and forty physicians engaged, programs can identify between 150 and 250 new suspects each month.

- If the philanthropy program is identifying 200 new suspects each month, approximately 25 percent, or in this case 50, of those names identified can be expected to result in a qualification visit. Therefore, each philanthropy officer can count on generating approximately 10 new qualification visits each month, using the rest of their time to manage their existing portfolio of prospects. If the philanthropy officer doesn't have time to make 10 new visits each month, the philanthropy program can elect to reduce the number of new suspects contacted for qualification visits.

Conclusion

Philanthropy has a unique ability to unlock the power of gratitude to help patients heal. When a patient is grateful for the care they have received, they are motivated to donate. When they donate, and express their gratitude, they are happier. When they are happier, they can make decisions that will help them to live longer lives.

Ultimately, an integrated grateful patient philanthropy program creates the environment and relationships which drive exceptional care and, ultimately more philanthropic revenue is generated for the organization. Through these additional resources, hospitals may find a pathway to support investments in the people, programs, facilities, and technology they need to create sustainable organizations in the future.

Grateful patient philanthropy programs are a continuation of the clinical experience and an **extension of the patient's** healing journey.

Chad Gobel is founder and CEO of the Gobel Group, the leader in engaging physicians in the philanthropic process to build robust grateful patient philanthropy programs that drive more and larger major gifts. Chad Gobel has more than 20 years of experience in philanthropic programs, including time as Associate Chairman of Development at The Cleveland Clinic and Chief Development Officer at the University of Rochester Medical Center. Alisa Stetzer, Senior Consultant for Strategic Research at Gobel Group, has 15 years' experience in identifying, developing and implementing best practices in hospital clinical strategy and operations.

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