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July 21, 2020

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Public Attitudes Regarding Hospitals and Physicians Encouraging Donations From Grateful Patients

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 Supplemental content

IMPORTANCE Philanthropy is an increasingly important source of support for health care institutions. There is little empirical evidence to inform ethical guidelines.

OBJECTIVE To assess public attitudes regarding specific practices used by health care institutions to encourage philanthropic donations from grateful patients.

DESIGN, SETTING, AND PARTICIPANTS Using the Ipsos KnowledgePanel, a probability-based sample representative of the US population, a survey solicited opinions from a primary cohort representing the general population and 3 supplemental cohorts (with high income, cancer, and with heart disease, respectively).

EXPOSURES Web-based questionnaire.

MAIN OUTCOMES AND MEASURES Descriptive analyses (with percentages weighted to make the sample demographically representative of the US population) evaluated respondents' attitudes regarding the acceptability of strategies hospitals may use to identify, solicit, and thank donors; perceptions of the effect of physicians discussing donations with their patients; and opinions regarding gift use and stewardship.

RESULTS Of 831 individuals targeted for the general population sample, 513 (62%) completed surveys, of whom 246 (48.0%) were women and 345 (67.3%) non-Hispanic white. In the weighted sample, 47.0% (95% CI, 42.3%-51.7%) responded that physicians giving patient names to hospital fundraising staff after asking patients' permission was definitely or probably acceptable; 8.5% (95% CI, 5.7%-11.2%) endorsed referring without asking permission. Of the participants, 79.5% (95% CI, 75.6%-83.4%) reported it acceptable for physicians to talk to patients about donating if patients have brought it up; 14.2% (95% CI, 10.9%-17.6%) reported it acceptable when patients have not brought it up; 9.9% (95% CI, 7.1%-12.8%) accepted hospital development staff performing wealth screening using publicly available data to identify patients capable of large donations. Of the participants, 83.2% (95% CI, 79.5%-86.9%) agreed that physicians talking with their patients about donating may interfere with the patient-physician relationship. For a hypothetical patient who donated \$1 million, 50.1% (95% CI, 45.4%-54.7%) indicated it would be acceptable for the hospital to show thanks by providing nicer hospital rooms, 26.0% (95% CI, 21.9%-30.1%) by providing expedited appointments, and 19.8% (95% CI, 16.1%-23.5%) by providing physicians' cell phone numbers.

CONCLUSIONS AND RELEVANCE In this survey study of participants drawn from the general US population, a substantial proportion did not endorse legally allowable approaches for identifying, engaging, and thanking patient-donors.

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JAMA. 2020;324(3):270-278. doi:10.1001/jama.2020.9442

Philanthropy is an increasingly important source of support for health care institutions seeking to sustain their missions in the face of decreasing research funding and clinical reimbursement.¹⁻³ An Association of American Medical Colleges survey conducted in 2018 indicated that the 123 US academic medical centers surveyed raised a mean of \$21.8 million each from nonalumni, nonstaff donors—totaling nearly \$2.7 billion in 2017-2018.⁴

The health care philanthropy literature describes practices used by development professionals at various stages of fundraising, including methods to identify patients capable of contributing substantially, cultivate relationships with potential patient-donors, and engage physicians in the process.⁵⁻⁷ Certain practices may raise ethical concerns, but there is little evidence to guide behavior in this context.⁸ A scoping review conducted in 2017⁹ revealed only 3 empirical articles discussing the ethics of fundraising from patients: 2 involved physicians^{10,11} and 1 involved 20 patient-donors.¹² No empirical studies were identified on this subject with nondonor patients or the general population.

A call for further empirical research was a key conclusion of a Summit on the Ethics of Grateful Patient Fundraising, which convened a multidisciplinary group representing the perspectives of patient-donors, physicians, bioethicists, lawyers, hospital administrators, development professionals, philanthropy scholars, and professional associations.¹³⁻¹⁵ Summit participants agreed on the importance and benefits of health care philanthropy while also identifying areas of potential concern that warranted further exploration. Public attitudes were believed to be relevant to guide practice and policy. This study was conducted to assess public attitudes about the acceptability of activities that are legally permissible and described in the development literature,⁵⁻⁷ including patient wealth screening, “concierge” services for patients who make large gifts, and physician engagement at different stages, along with attitudes regarding donor control over gifts.

Methods

Sampling and Data Collection

After approval by the University of Michigan institutional review board, we engaged the Ipsos KnowledgePanel to solicit perspectives from a primary cohort of approximately 500 adults in the general US population and 3 supplemental cohorts of (1) 250 individuals with self-reported annual household income \$250 000 or greater (those more likely to make substantial donations), (2) 250 individuals who reported having been diagnosed with cancer, and (3) 250 individuals with a self-reported history of heart disease (groups likely to have had extensive interactions with the health system). The primary sample size, 500, was selected to ensure that descriptive estimates of binary measures (such as acceptability) would have 95% confidence intervals with maximum width of 9 percentage points.

Ipsos uses probability-based sampling¹⁶ with address-based methods to randomly recruit households to the KnowledgePanel; the aim is to assemble a sample representative of the US population. Panel members provide in-

Key Points

Question What are public attitudes regarding legally allowed practices used to raise funds from grateful patients?

Findings In a survey study that included 513 members of a US national survey panel with data weighted to be representative of the US population, 47.0% responded that physicians giving patient names to hospital fundraising staff after asking patients' permission was definitely or probably acceptable; 8.5% endorsed referring without asking permission. Of the participants, 83.2% strongly agreed or agreed that physicians talking with their patients about donating may interfere with the patient-physician relationship.

Meaning In this survey study, a substantial proportion of participants did not endorse legally allowable approaches for identifying, engaging, and thanking patient-donors.

formed consent to participate and receive modest incentives (such as raffles for cash or prizes) to encourage participation.

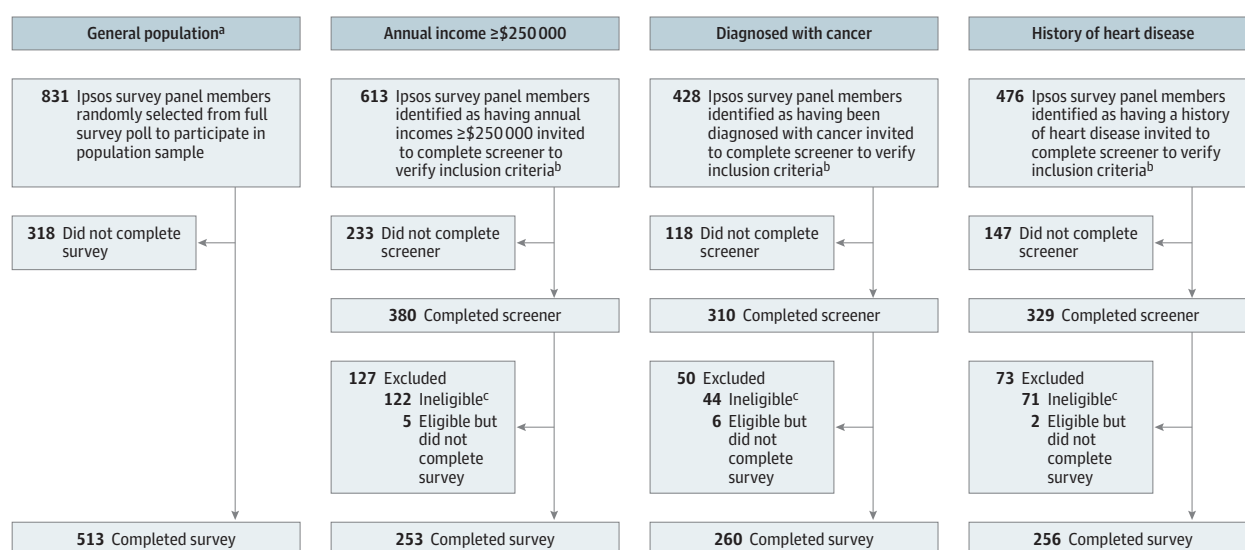
In February 2019, 2348 individuals were sampled. In addition to sampling from the overall panel to create a cohort representative of the general US population, screening questions from the profile surveys were used to select 3 supplemental samples as detailed in **Figure 1**. See the eMethods and eTables 1-4 in **Supplement 1** for further details.

Instrument Development and Measures

A multidisciplinary group of experts developed an original survey instrument (eAppendix in **Supplement 2**) after literature review, which included prior qualitative and quantitative studies in this area. Using an iterative design process,¹⁷ we followed established practices for questionnaire design, including detailed cognitive pretesting with 9 patients recruited through a University of Michigan patient recruitment pool (UM Health Research), using think-aloud reasoning and verbal probing to ensure validity.¹⁸

To evaluate respondents' perceptions about the acceptability of strategies hospitals may use to thank donors, we first presented a scenario of a 68-year-old patient who recently received treatment for a serious illness and donated money to help the hospital do research that might allow for better care for all patients. Respondents were asked if it would be acceptable for the hospital to show thanks to the patient by giving them a plaque or certificate of thanks, a nicer hospital room, ability to get physicians' appointments faster, or physicians' cell phone numbers for enhanced access. Respondents' appraisal regarding acceptability was ascertained across varying hypothetical donation amounts, ranging from \$100 to \$1 000 000. Next, we asked participants to rate the acceptability of 8 ways that hospitals currently identify and solicit donors, using a 4-point scale from definitely acceptable to definitely not acceptable (dichotomized for analysis as definitely or probably acceptable vs definitely or probably not acceptable). The survey also explored participants' attitudes about the effect of physicians discussing donations with their patients, the effect of donating, and training and participation of physicians in fundraising (7 items, 4-point response scale from strongly agree to strongly disagree, dichotomized for analysis as strongly agree or agree vs strongly disagree or disagree).

Figure 1. Survey Sampling and Completion



^a General population sample based on sample representative of US general population maintained by Ipsos; other samples based on subsampling for the identified characteristics. Individuals were not excluded from a sample because they met eligibility for another sample, but no individual contributed to more than 1 sample.

^b Based on Ipsos survey panel profile completed by panel members prior to study commencement.

^c Those deemed ineligible were individuals believed to be likely to qualify for a supplemental sample (such as an individual whose income in the survey panel profile was high) but whose responses to screening questions indicated that they were not eligible (for example, if their current income was no longer high), as further discussed in the eMethods in Supplement 1.

Regarding gift use and stewardship, we inquired, “When a hospital receives a gift from a grateful patient, sometimes the patient says how the donation should be used. For example, the donor might want the donation to support research on the illness the donor has. How much control should donors have over where their donations go?” Responses were collected on a 4-point scale from complete control to no control (dichotomized for analysis as complete control or moderate control vs no control or a little control). We also asked respondents to “Imagine a large donation has been made to the hospital. Hospital officials need to decide how to use the donation. When deciding how to use the donation, how important do you think it would be for the hospital to include the input of people who receive care from the hospital but do not have the ability to make a large donation?” Responses were collected on a 4-point scale from extremely important to not at all important (dichotomized for analysis as extremely important or moderately important vs not at all important or slightly important).

We explained, “When a large donation (for example, \$100 000) is made to a hospital, usually a portion of the donation will be used to support the general needs of the hospital and the community it serves.” We asked how much of a \$100 000 donation should be used for what the donor says it should be for (in percent) and how much should be used for what the hospital and community need (which the online survey automatically calculated for the respondent as 100% minus the previous response, with the respondent allowed to change the initial response until satisfied).

Demographic characteristics provided from the Ipsos profile surveys included sex, age, race/ethnicity, and education. Race/ethnicity was included to try to ensure that the sample was rep-

resentative of the general US population and was determined by Ipsos based on respondent self-report, using fixed categories. We assessed the number of encounters with physicians and hospital stays in the prior year, total household charitable giving in the past year, and total lifetime donations to hospitals or medical centers where respondents or loved ones had received care.

Statistical Analysis

Survey weights supplied by Ipsos were designed to make the responding sample representative of the total US population (eMethods in Supplement 1). The dimensions included to create the survey weights were sex, age, race/ethnicity, education, census region, home ownership status, metropolitan area, and internet access.

Descriptive statistics were generated for each item within the general population sample and the supplemental samples (high income and those previously diagnosed with cancer or heart disease). All statistics are reported as unweighted frequencies and weighted percentages to maximize transparency, using SAS version 9.4 (SAS Institute Inc). For simplicity of presentation of results, scales were dichotomized as described above; response distributions are reported in eTables 5 and 6 in Supplement 1. Because the rate of item non-response was very low (<5% for all items), missing data were ignored.

Results

A total of 513 participants from the general population sample completed surveys (completion rate, 62%), as did 253 from the supplemental sample of high-income individuals,

260 from the supplemental sample of individuals with cancer, and 256 from the supplemental sample of individuals with heart disease (Figure 1). Respondents in the general population sample differed significantly from nonrespondents for sex, race, education, employment, and head-of-household status (eTables 1-4 in Supplement 1). Characteristics of the respondents are shown in Table 1. The general population sample included 246 women (48.0%) and 267 men (52.0%); the high-income sample included 107 women (42.3%) and 146 men (57.7%); the patients with cancer included 132 women (50.8%) and 128 men (49.2%); the patients with heart disease included 83 women (32.4%) and 173 men (67.6%). In the general population sample, 345 (67.3%) were non-Hispanic white, 56 (10.9%) were non-Hispanic black, 44 (8.6%) were non-Hispanic other race, and 68 (13.3%) were Hispanic. Proportions reporting that they had ever donated to hospitals were 32.2% (95% CI, 27.9%-36.6%) of the general population sample, 34.4% (95% CI, 28.1%-40.8%) of the patients with cancer, 32.0% (95% CI, 25.3%-38.6%) of the patients with heart disease, and 45.5% (95% CI, 37.8%-53.1%) of the high-income individuals.

Figure 2 shows respondents' perceptions of the acceptability of various practices used by hospitals to thank donors. A minority of respondents within each cohort considered acceptable forms of recognition that were related to access, such as faster appointments or direct cell phone numbers of physicians. This was true even when the scenario involved extremely large monetary donations. When the general population sample considered a hypothetical patient who donated \$1 million, 50.1% (95% CI, 45.4%-54.7%) indicated it would be acceptable for the hospital to show thanks by providing nicer hospital rooms, 26.0% (95% CI, 21.9%-30.1%) expedited appointments, and 19.8% (95% CI, 16.1%-23.5%) physicians' cell phone numbers. For the hypothetical patient who donated \$1 million, 37.5% (95% CI, 30.0%-45.0%) of the high-income sample, 23.6% (95% CI, 18.1%-29.2%) of those with cancer, and 23.3% (95% CI, 16.8%-29.8%) of those with heart disease indicated it would be acceptable for the hospital to show thanks by providing expedited appointments.

Many respondents indicated that specific ways that hospitals currently identify and solicit donors were not acceptable (Table 2). Forty-seven percent (95% CI, 42.3%-51.7%) of the general population sample, 58.6% (95% CI, 51.3%-65.8%) of the high-income sample, 53.3% (95% CI, 46.7%-59.8%) of those with cancer, and 41.0% (95% CI, 33.8%-48.3%) of those with heart disease responded that it was acceptable for physicians to give hospital fundraising staff the names of patients they think are grateful and wealthy enough to donate after talking to the patients to get their permission. Of the general population sample, 8.5% (95% CI, 5.7%-11.2%) indicated it was acceptable to do so without explicit permission, as did 10.9% (95% CI, 5.9%-15.9%) of the high-income sample, 6.3% (95% CI, 3.1%-9.5%) of those with cancer, and 6.0% (95% CI, 3.0%-9.0%) of those with heart disease. Of the general population sample, 79.5% (95% CI, 75.6%-83.4%) responded that it was acceptable for physicians to talk to patients about donating to the hospital if the patient brought up the topic, as did 87.6% (95% CI, 82.3%-92.5%) of the high-income sample,

83.6% (95% CI, 78.8%-88.3%) of those with cancer, and 87.6% (95% CI, 83.3%-92.0%) of those with heart disease. Of the general population sample, 14.2% (95% CI, 10.9%-17.6%) reported it acceptable if the patient has not brought up the topic, as did 19.5% (95% CI, 13.0%-26.1%) of the high-income sample, 14.5% (95% CI, 9.9%-19.1%) of those with cancer, and 11.1% (95% CI, 6.9%-15.3%) of those with heart disease. When asked about physicians sending letters to their wealthy patients asking if someone can contact them about making a donation to the hospital, 37.7% (95% CI, 33.2%-42.3%) of the general population sample, 37.4% (95% CI, 30.1%-44.7%) of the high-income sample, 31.7% (95% CI, 25.6%-37.8%) of those with cancer, and 40.0% (95% CI, 32.8%-47.2%) of those with heart disease considered this acceptable. However, 9.9% (95% CI, 7.1%-12.8%) of the general population sample, 19.9% (95% CI, 14.0%-25.9%) of the high-income sample, 6.5% (95% CI, 3.1%-9.8%) of those with cancer, and 9.3% (95% CI, 5.6%-13.0%) of those with heart disease reported it acceptable for hospital fundraising staff to check the value of patients' homes or other public information to ascertain which patients may be potential large donors.

As detailed in Table 3, 85.2% (95% CI, 81.9%-88.6%) of respondents from the general population sample agreed that patients feel good when they donate to the hospital or health center where they receive their medical care, and 77.0% (95% CI, 73.1%-80.9%) agreed that patients feel good by donating to support the physician who cared for them. Of the general population sample, 83.2% (95% CI, 79.5%-86.9%) agreed that physicians talking with their patients about donating might interfere with the patient-physician relationship, and 90.7% (95% CI, 87.7%-93.7%) agreed that patients may feel pressure to donate if asked to do so by their physician. In addition, 44.5% (95% CI, 39.9%-49.2%) agreed that all physicians should receive training on how to have discussions with patients about donating money, and 31.0% (95% CI, 26.5%-35.4%) agreed that all physicians should be expected to participate in fundraising for their hospital.

When considering how donations should be used, 59.2% (95% CI, 54.6%-63.8%) of the general population sample and 59.2% (95% CI, 52.1%-66.3%) of the high-income sample indicated that it was extremely important or moderately important to include the input of people who receive care from the hospital but do not have the ability to make a large donation. When asked about the degree of control donors should have over the use of their donations, 91.5% (95% CI, 88.0%-95.0%) of the high-income sample and 78.7% (95% CI, 74.8%-82.6%) of the general population sample favored donors having complete control or moderate control. When theoretically allocating a \$100 000 donation, the estimated mean response in each of the samples indicated that a substantial majority of the donation should be for donor-specified use. In the general population sample, the estimated mean response was that 66.0% (95% CI, 63.2%-68.8%) should be for donor-specified use and 34.0% (95% CI, 31.2%-\$36.9%) should be left to be used for what the hospital and community need; in the high-income sample, the estimated mean response was that the amount for donor-specified use should be 74.1% (95% CI, 70.3%-78.0%). Within the supplemental sample of patients

Table 1. Characteristics of the 1282 Respondents Who Shared Their Perspectives About Grateful Patients Making Donations to the Health Care Institutions That Served Them

Characteristic/level	No. (weighted %) [95% CI] ^a			
	General population (n = 513) ^b	Annual income ≥\$250 000 (n = 253)	Diagnosed with cancer (n = 260)	History of heart disease (n = 256)
Age, y				
18-34	110 (29.2) [24.6-33.8]	27 (22.3) [13.9-30.7]	10 (3.9) [1.5-6.2]	9 (5.4) [1.9-9.0]
35-44	78 (16.9) [13.3-20.4]	47 (20.4) [14.8-26.0]	7 (5.0) [1.4-8.6]	6 (7.0) [1.6-12.5]
45-54	83 (15.6) [12.3-18.8]	63 (24.5) [18.6-30.4]	18 (9.3) [5.0-13.5]	12 (7.0) [2.3-11.8]
55-64	116 (19.1) [15.7-22.5]	59 (19.7) [14.1-25.2]	67 (24.3) [18.8-29.7]	73 (24.7) [18.9-30.4]
≥65	126 (19.2) [16.0-22.5]	57 (13.1) [9.2-17.1]	158 (57.7) [51.1-64.2]	156 (55.8) [48.4-63.3]
Sex				
Men	267 (48.4) [43.8-53.1]	146 (54.0) [46.3-61.8]	128 (48.6) [42.1-55.2]	173 (59.4) [52.1-66.8]
Women	246 (51.6) [46.9-56.2]	107 (46.0) [38.2-53.7]	132 (51.4) [44.8-57.9]	83 (40.6) [33.2-47.9]
Race/ethnicity ^c				
Non-Hispanic				
White	345 (63.5) [58.9-68.1]	205 (72.2) [64.8-79.7]	218 (82.2) [76.9-87.5]	217 (77.2) [70.2-84.1]
Black	56 (11.9) [8.8-14.9]	7 (4.7) [0.9-8.5]	13 (7.5) [3.3-11.6]	6 (6.9) [1.6-12.3]
Other	44 (8.4) [5.6-11.2]	28 (13.6) [7.9-19.4]	8 (2.5) [0.7-4.4]	13 (4.6) [1.7-7.4]
Hispanic	68 (16.2) [12.6-19.9]	13 (9.4) [4.3-14.5]	21 (7.8) [4.4-11.2]	20 (11.3) [6.4-16.3]
Marital status				
Married	315 (57.7) [53.1-62.4]	208 (73.9) [65.7-82.0]	180 (68.7) [62.6-74.7]	167 (63.9) [56.8-71.0]
Widowed	18 (2.5) [1.3-3.7]	4 (1.2) [0.0-2.4]	19 (8.4) [4.5-12.3]	22 (8.1) [4.2-12.0]
Divorced	46 (8.9) [6.3-11.5]	9 (3.8) [0.8-6.7]	31 (11.1) [7.2-15.1]	44 (17.3) [11.8-22.9]
Separated	9 (1.6) [0.5-2.7]	3 (1.3) [0.0-2.9]	3 (0.9) [0.0-1.9]	2 (1.3) [0.0-3.3]
Never married	94 (21.7) [17.6-25.8]	19 (15.3) [7.4-23.2]	23 (9.7) [5.7-13.6]	18 (8.1) [3.8-12.4]
Living with partner	31 (7.6) [5.0-10.2]	10 (4.6) [1.6-7.7]	4 (1.3) [0.0-2.5]	3 (1.3) [0.0-2.9]
Education				
High school or less	177 (39.5) [34.9-44.2]	6 (8.9) [1.9-15.9]	97 (33.7) [27.6-39.7]	106 (42.3) [35.1-49.5]
Some college (no degree)	138 (28.2) [24.0-32.4]	30 (19.8) [12.7-26.9]	66 (28.5) [22.5-34.6]	66 (30.1) [23.2-37.1]
Bachelor's degree or higher	198 (32.3) [28.1-36.4]	217 (71.3) [62.8-79.9]	97 (37.8) [31.4-44.2]	84 (27.6) [21.1-34.1]
Household income, \$				
0-24 999	67 (14.5) [11.1-17.9]	0	32 (10.9) [7.0-14.7]	50 (15.8) [11.0-20.5]
25 000-39 999	61 (13.4) [10.1-16.7]	0	34 (12.9) [8.6-17.2]	36 (15.7) [10.0-21.4]
40 000-74 999	108 (22.4) [18.4-26.3]	0	66 (23.6) [18.1-29.0]	63 (25.9) [19.4-32.4]
75 000-124 999	133 (25.8) [21.8-29.8]	0	65 (23.6) [18.3-29.0]	55 (20.5) [14.9-26.2]
125 000-249 999	116 (19.3) [15.9-22.8]	0	59 (27.6) [21.4-33.8]	50 (21.5) [15.2-27.9]
≥250 000	28 (4.6) [2.8-6.4]	253 (100) [100-100]	4 (1.5) [0-2.9]	2 (0.6) [0-1.4]
Head of household				
Yes	425 (79.3) [75.2-83.3]	228 (81.8) [73.7-89.8]	233 (90.4) [86.7-94.0]	229 (88.6) [83.8-93.3]
No	88 (20.7) [16.7-24.8]	25 (18.2) [10.2-26.3]	27 (9.6) [6.0-13.3]	27 (11.4) [6.7-16.2]
US region				
Northeast	100 (17.8) [14.4-21.2]	66 (23.9) [17.4-30.4]	43 (18.8) [13.5-24.1]	49 (19.6) [13.9-25.4]
Midwest	117 (20.8) [17.2-24.4]	42 (17.5) [10.9-24.0]	69 (21.5) [16.5-26.5]	54 (22.0) [15.8-28.2]
South	183 (37.7) [33.2-42.2]	73 (31.0) [23.9-38.0]	92 (36.3) [30.0-42.7]	106 (38.6) [31.4-45.8]
West	113 (23.7) [19.7-27.8]	72 (27.7) [21.2-34.1]	56 (23.3) [17.7-28.9]	47 (19.7) [14.0-25.5]
No. of physician visits in past year ^{d,e}				
None	72 (15.7) [12.2-19.3]	27 (11.7) [6.8-16.6]	3 (0.8) [0-1.7]	2 (1.2) [0-3.1]
1	108 (22.4) [18.4-26.4]	54 (21.3) [15.3-27.2]	12 (5.2) [2.1-8.2]	11 (6.7) [2.3-11.1]
2	93 (18.7) [15.0-22.3]	64 (28.6) [21.1-36.1]	40 (14.9) [10.4-19.5]	34 (13.2) [8.1-18.4]
3	79 (15.8) [12.4-19.3]	37 (14.9) [9.9-20.0]	33 (12.1) [8.0-16.3]	35 (12.6) [8.1-17.0]
4	59 (10.6) [7.8-13.3]	17 (5.6) [2.7-8.5]	34 (13.2) [8.8-17.6]	50 (19.9) [14.0-25.9]
5-9	59 (11.4) [8.4-14.3]	29 (10.7) [6.2-15.1]	80 (31.7) [25.4-37.9]	75 (28.1) [21.6-34.6]
≥10	29 (5.4) [3.4-7.4]	21 (7.2) [3.5-10.9]	54 (22.1) [16.5-27.6]	45 (18.3) [12.6-24.1]

(continued)

Table 1. Characteristics of the 1282 Respondents Who Shared Their Perspectives About Grateful Patients Making Donations to the Health Care Institutions That Served Them (continued)

Characteristic/level	No. (weighted %) [95% CI] ^a			
	General population (n = 513) ^b	Annual income ≥\$250 000 (n = 253)	Diagnosed with cancer (n = 260)	History of heart disease (n = 256)
No. of hospital stays in past year ^{d,e}				
None	443 (89.0) [86.0-91.9]	230 (92.1) [87.6-96.6]	202 (77.3) [71.8-82.8]	186 (75.0) [68.9-81.2]
1	31 (6.0) [3.8-8.2]	10 (3.1) [1.0-5.2]	40 (16.4) [11.5-21.3]	33 (11.2) [6.8-15.5]
2	10 (2.2) [0.7-3.7]	4 (1.1) [0.2-3]	10 (3.3) [1.1-5.4]	15 (5.8) [2.6-9.0]
≥3	14 (2.8) [1.3-4.4]	5 (3.7) [0.7-6]	7 (3.0) [0.7-5.3]	20 (8.0) [4.1-12.0]
Charitable donations in past year, \$ ^{d,f}				
0	77 (17.5) [13.8-21.3]	12 (5.4) [1.7-9.1]	25 (9.1) [5.4-12.9]	38 (17.8) [11.8-23.8]
1-99	86 (18.7) [14.9-22.5]	5 (2.7) [0.2-5.1]	25 (9.2) [5.6-12.9]	37 (14.0) [9.2-18.9]
100-999	130 (23.8) [20.0-27.6]	45 (16.8) [11.9-21.8]	85 (31.6) [25.6-37.7]	78 (30.5) [23.7-37.2]
1000-9999	127 (21.4) [17.8-25.0]	107 (39.7) [32.4-47.1]	70 (29.5) [23.4-35.7]	58 (22.0) [15.8-28.2]
10 000-99 999	25 (4.2) [2.5-5.9]	44 (17.6) [11.1-24.1]	13 (4.5) [2.0-7.0]	11 (3.7) [1.1-6.2]
≥100 000	5 (0.8) [0.1-1.5]	19 (8.7) [3.5-13.8]	3 (1.3) [0.2-2.8]	4 (1.6) [0.3-4]
Prefer not to answer or refuse to answer	63 (13.6) [10.3-17.0]	21 (9.1) [4.7-13.6]	39 (14.6) [10.1-19.1]	30 (10.4) [6.3-14.5]
Lifetime donations to hospitals, \$ ^{d,g}				
0	246 (47.0) [42.4-51.6]	103 (37.8) [30.6-44.9]	117 (43.7) [37.3-50.2]	123 (48.8) [41.4-56.1]
1-99	30 (6.4) [4.1-8.7]	8 (5.2) [0.7-9.7]	11 (3.9) [1.4-6.4]	15 (5.9) [2.6-9.2]
100-999	49 (10.4) [7.5-13.4]	25 (8.0) [4.5-11.5]	28 (11.7) [7.4-16.1]	34 (12.5) [8.1-16.9]
1000-9999	51 (9.5) [6.7-12.3]	41 (16.8) [10.9-22.7]	26 (11.0) [6.7-15.4]	22 (7.8) [4.4-11.2]
10 000-99 999	29 (5.0) [3.1-6.9]	29 (9.9) [6.0-13.7]	14 (5.2) [2.4-8.0]	10 (4.9) [1.3-8.5]
≥100 000	5 (0.9) [0.1-1.6]	15 (5.6) [2.2-9.0]	5 (2.6) [0.3-4.9]	2 (0.9) [0.2-2.0]
Prefer not to answer or refuse to answer	103 (20.7) [17.0-24.5]	32 (16.8) [10.0-23.6]	59 (21.8) [16.6-27.1]	50 (19.3) [13.5-25.0]

^a Survey weights supplied by Ipsos were designed to make the responding sample representative of the total US population.

^b Sample representative of the general population. Does not exclude respondents who may be high income, diagnosed with cancer, or have a history of heart disease, nor do supplemental samples exclude individuals eligible for other supplemental samples. Individuals are included in only 1 sample.

^c Race/ethnicity was provided grouped together in this way by Ipsos, and results are based on self-report.

^d Responses are self-reported by participants. Please see survey included in

Supplement 2 for full question prompts.

^e Numbers may not sum to column totals because the answer choice "I don't know" was excluded.

^f Question stem, "How much money did you or your household donate to charitable causes in the last calendar year (January to December 2018)? (Please estimate to the best of your ability)."

^g Question stem, "How much money in total over your lifetime have you or your household donated to a hospital or medical center where you or your loved ones receive or have received care? (Please estimate to the best of your ability)."

with cancer, this was 71.6% (95% CI, 68.0%-75.3%) and within the supplemental sample of patients with heart disease it was 67.9% (95% CI, 63.8%-72.0%).

Discussion

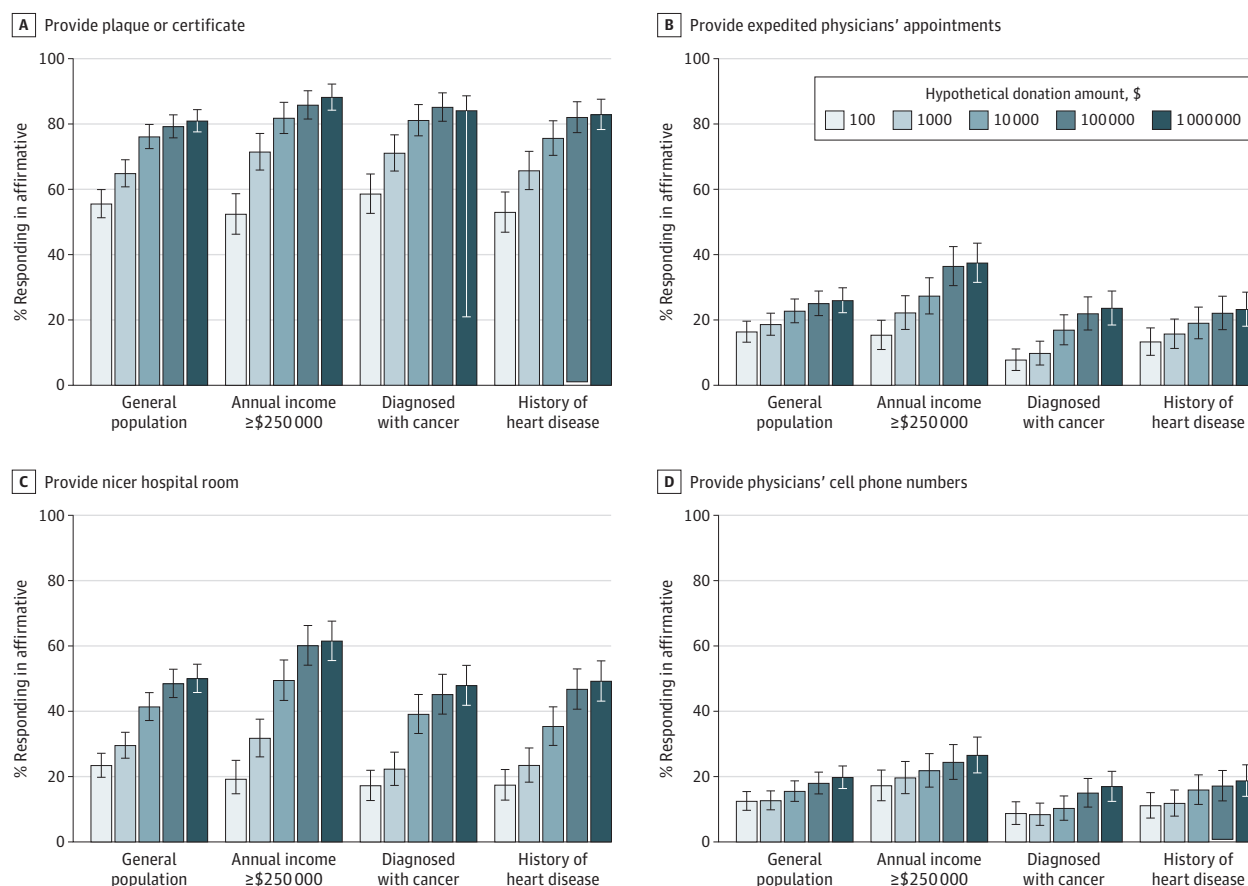
In this survey study, a substantial proportion of participants drawn from a sample of the general population and from 3 supplemental samples did not endorse a number of legally allowable approaches for identifying, engaging, and thanking patient-donors as acceptable. These findings may help to inform practice and policy by illuminating where current development practices¹⁹ may diverge from what stakeholders—specifically, some of the general population and patients—might consider acceptable.

Few respondents found wealth screening or referrals to development staff without patients' prior consent to be acceptable. These attitudes are consistent with concerns about privacy and confidentiality that have been discussed in the legal literature^{20,21} and raised by ethicists²² regarding a 2013 up-

date to the Health Insurance Portability and Accountability Act Privacy Rule that permits development professionals to access certain types of information without patients' explicit consent. The Department of Health and Human Services (HHS) stated that a goal motivating the 2013 changes was a desire to "streamline... fundraising efforts and ensure that individuals were sent communications about campaigns that would be meaningful to their experiences"; they noted that only a small minority of commenters opposed the change because of "privacy concerns."²³ Although it is unclear whether the public was truly informed or engaged in deliberating about this particular policy change, the comment from HHS signals the sensitivity of policy makers to the opinions of the broader public.

The physician's role in fundraising raises particular ethical concerns. Current professional society guidelines permit physicians to engage in soliciting donations from patients. In 2004, the American Medical Association Council on Ethical and Judicial Affairs stated: "If they do not shift the focus of the patient-physician relationship away from the patient's welfare and are conducted in a manner that respects patient dignity and rights, and benefits the community, solicitation

Figure 2. Perceived Acceptability of Ways That Hospitals Might Thank Donors—Responses From a Total of 1282 Individuals



Perceptions collected in a survey study of a sample representative of the general population and 3 supplemental samples about the acceptability of strategies hospitals may use to thank donors. Respondents were presented with a scenario of a 68-year-old individual who recently received treatment for a serious illness and donated money to help the hospital do research that might allow for better care for all patients. Respondents were asked if it would be

acceptable for the hospital to show thanks to the patient by giving them a plaque or certificate of thanks, a nicer hospital room, ability to get physicians' appointments faster, or physicians' cell phone numbers for enhanced access. Respondents' appraisal regarding acceptability was ascertained across varying hypothetical donation amounts, ranging from \$100 to \$1 000 000.

activities can constitute an appropriate use of physicians' influential role in society.²⁴ The complete council report discusses issues of patient welfare (emphasizing greater separation between the request and the clinical encounter), undue pressure (extolling approaches where the patient initiates the conversation or is prompted by general fundraising materials in waiting areas rather than having physicians raise the issue), and privacy and confidentiality (stating that information about diagnosis and service should only be released with permission). It concludes that "solicitation must not occur during the clinical encounter"²⁴ but stops short of specifying exactly how and when it may or should occur.

Information regarding what physicians are asked to do to support fundraising from patients is scarce. In the only large physician survey on this subject, of 405 oncologists at National Cancer Institute-designated Comprehensive Cancer Centers, 71% reported that they had been exposed to development staff; 51% had been asked to refer patients to development, and 32% had been asked to solicit donations from their patients.¹⁰ The findings of the present study may pro-

vide insights into the expectations of the public regarding physicians' behavior in the context of philanthropy. In the oncologist survey, 73% of respondents endorsed concerns that development efforts might interfere with the patient-physician relationship; these concerns were shared by 83% of the general population in the present study. The inherent vulnerability of patients and the unique importance of trust in the patient-physician relationship suggest that great caution is necessary in this context and that ethical guidelines merit further specification.

Limitations

This study has several limitations. First, the survey had a 62% completion rate, with potentially important differences between respondents and nonrespondents which might have led to biased results. Although weighting helps to ensure that analyses reflect the demographic characteristics of the underlying population sampled, this does not eliminate the possibility that those who chose to respond might be systematically different in their attitudes from those who did not.

Table 2. Attitudes of Respondents Regarding Activities to Encourage Donations (N = 1282)

Activity ^a	Responding acceptable, No. (weighted %) [95% CI] ^{b,c}			
	General population (n = 513) ^d	Annual income ≥\$250 000 (n = 253)	Diagnosed with cancer (n = 260)	History of heart disease (n = 256)
Physicians asking for donations at public meetings that patients may attend	272 (55.5) [50.8-60.2]	170 (65.5) [58.0-73.0]	145 (57.4) [50.8-63.9]	143 (58.0) [50.7-65.3]
Hospital fundraising staff posting information in the waiting rooms of physicians' offices about how to donate	378 (76.2) [72.3-80.2]	198 (77.8) [71.2-84.4]	199 (77.2) [71.7-82.6]	175 (73.1) [67.0-79.2]
Physicians giving hospital fundraising staff the names of grateful patients believed to be wealthy enough to donate				
After talking to the patients first to get their permission	234 (47.0) [42.3-51.7]	143 (58.6) [51.3-65.8]	136 (53.3) [46.7-59.8]	106 (41.0) [33.8-48.3]
Without talking to the patients first	39 (8.5) [5.7-11.2]	24 (10.9) [5.9-15.9]	18 (6.3) [3.1-9.5]	17 (6.0) [3.0-9.0]
Physician talking to a patient about donating				
If the patient brought it up	406 (79.5) [75.6-83.4]	222 (87.6) [82.6-92.5]	213 (83.6) [78.8-88.3]	217 (87.6) [83.3-92.0]
Even if the patient has not brought it up	70 (14.2) [10.9-17.6]	43 (19.5) [13.0-26.1]	37 (14.5) [9.9-19.1]	32 (11.1) [6.9-15.3]
Physicians sending letters to their wealthy patients asking if they can be contacted about making a donation to the hospital	190 (37.7) [33.2-42.3]	93 (37.4) [30.1-44.7]	82 (31.7) [25.6-37.8]	106 (40.0) [32.8-47.2]
Hospital fundraising staff checking the value of patients' homes or other public information to find out which patients could make a large donation	47 (9.9) [7.1-12.8]	53 (19.9) [14.0-25.9]	16 (6.5) [3.1-9.8]	27 (9.3) [5.6-13.0]

^a Question stem, "For the next few statements, we would like your opinion on activities some hospitals use to encourage donations. Please tell us how acceptable or unacceptable each of these activities would be."

^b Survey weights supplied by Ipsos were designed to make the responding sample representative of the total US population.

^c Acceptability was determined on a 4-point scale (definitely acceptable, probably

acceptable, probably not acceptable, definitely not acceptable) that was dichotomized for presentation here; full distribution provided in [Supplement 1](#).

^d Sample representative of the general population. Does not exclude respondents who may be high income, diagnosed with cancer, or have a history of heart disease, nor do supplemental samples exclude individuals eligible for other supplemental samples. Individuals are included in only 1 sample.

Table 3. Attitudes of 1282 Survey Respondents About the Effect of Physicians Discussing Donations With Patients, Their Training, and Participation in Fundraising Efforts

Item	Responding that they agree, No. (weighted %) [95% CI] ^{a,b}			
	General population (n = 513) ^c	Annual income ≥\$250 000 (n = 253)	Diagnosed with cancer (n = 260)	History of heart disease (n = 256)
Physicians talking with their patients about donating may interfere with the patient-physician relationship ^d	431 (83.2) [79.5-86.9]	215 (84.1) [78.0-90.2]	228 (87.3) [82.8-91.9]	220 (85.9) [80.7-91.0]
Patients feel good when they donate to the hospital or health center where they receive their medical care ^d	432 (85.2) [81.9-88.6]	209 (85.8) [81.0-90.7]	229 (89.0) [84.7-93.3]	208 (83.7) [78.5-88.9]
Patients feel good when donating to support the physician who cared for them ^d	386 (77.0) [73.1-80.9]	198 (83.8) [78.9-88.7]	190 (75.7) [70.1-81.2]	177 (74.8) [68.9-80.7]
Patients may feel pressure to donate if asked by their physician ^d	470 (90.7) [87.7-93.7]	225 (88.3) [82.7-93.9]	237 (93.1) [89.8-96.3]	227 (89.9) [85.2-94.6]
All physicians should receive training on how to have discussions with patients about donating money ^e	221 (44.5) [39.9-49.2]	105 (44.7) [37.1-52.3]	86 (32.3) [26.2-38.4]	91 (38.1) [30.7-45.5]
Only physicians who show interest in fundraising should be required to receive training on how to have discussion with patients about donating ^e	272 (53.3) [48.7-58.0]	129 (47.5) [39.9-55.0]	156 (61.8) [55.4-68.2]	145 (57.8) [50.5-65.2]
All physicians should be expected to participate in fundraising for their hospital ^e	143 (31.0) [26.5-35.4]	41 (19.9) [13.5-26.2]	38 (15.2) [10.4-19.9]	47 (20.4) [14.1-26.7]

^a Survey weights supplied by Ipsos were designed to make the responding sample representative of the total US population.

^b Agreement was determined on a 4-point scale (strongly agree, agree, disagree, strongly disagree) that was dichotomized for presentation here; full distribution available in [Supplement 1](#).

^c Sample representative of the general population. Does not exclude respondents who may be high income, diagnosed with cancer, or have a history of heart

disease, nor do supplemental samples exclude individuals eligible for other supplemental samples. Individuals are included in only 1 sample.

^d Question stem, "Please tell us how much you agree or disagree with the following statements."

^e Question stem, "Lastly, we want to ask you about what hospitals should expect of doctors with respect to fundraising. Please tell us how much you agree or disagree with the following statements."

Second, it is impossible to know whether the supplemental samples (those with a history of heart disease or cancer, and those with high income) were representative of these groups

because assignment was based on self-report. Third, participants may not have fully understood the fundraising practices described; cognitive pretesting of the instrument and

grounding the work in prior qualitative research helps to reduce this risk. Further research using approaches like public deliberation²⁵ might complement the current study, given the complexity of the policy considerations involved. Further research is also needed to evaluate how often institutions are currently using the approaches that most of the current survey sample did not find acceptable.

Conclusions

In this survey study of participants drawn from the general US population, a substantial proportion did not endorse legally allowable approaches for identifying, engaging, and thanking patient-donors.

ARTICLE INFORMATION

Accepted for Publication: May 15, 2020.

Author Contributions: Dr Jaggi and Mr Griffith had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Jaggi, Carrese, Collins, Kao, Konrath, Tovino, Wheeler, Wright.
Acquisition, analysis, or interpretation of data: Jaggi, Griffith, Collins, Kao, Wheeler, Wright.
Drafting of the manuscript: Jaggi, Griffith, Konrath, Wheeler, Wright.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Griffith.

Obtained funding: Jaggi.

Administrative, technical, or material support: Jaggi.
Supervision: Jaggi.

Conflict of Interest Disclosures: Dr Jaggi reported holding stock options as compensation for her advisory board role in Equity Quotient, a company that evaluates culture in health care companies; receiving personal fees from Amgen and Vizient; and receiving grants from the National Institutes of Health, the Doris Duke Foundation, the Greenwall Foundation, the Susan G. Komen Foundation, and Blue Cross Blue Shield of Michigan for the Michigan Radiation Oncology Quality Consortium. Dr Wright reported receiving support as the Anne Gaines and G. Thomas Miller Professor of Medicine through the Johns Hopkins Center for Innovative Medicine. No other authors reported disclosures.

Funding/Support: This work was funded by a Making a Difference grant award from the Greenwall Foundation.

Role of the Funder/Sponsor: The Greenwall Foundation had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Additional Contributions: We thank Megan Knaus Sabatini, MPH, and Lauren Szczygiel, PhD, Center for Bioethics and Social Sciences in Medicine at the University of Michigan, for their administrative and editing support; they were compensated for these contributions.

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